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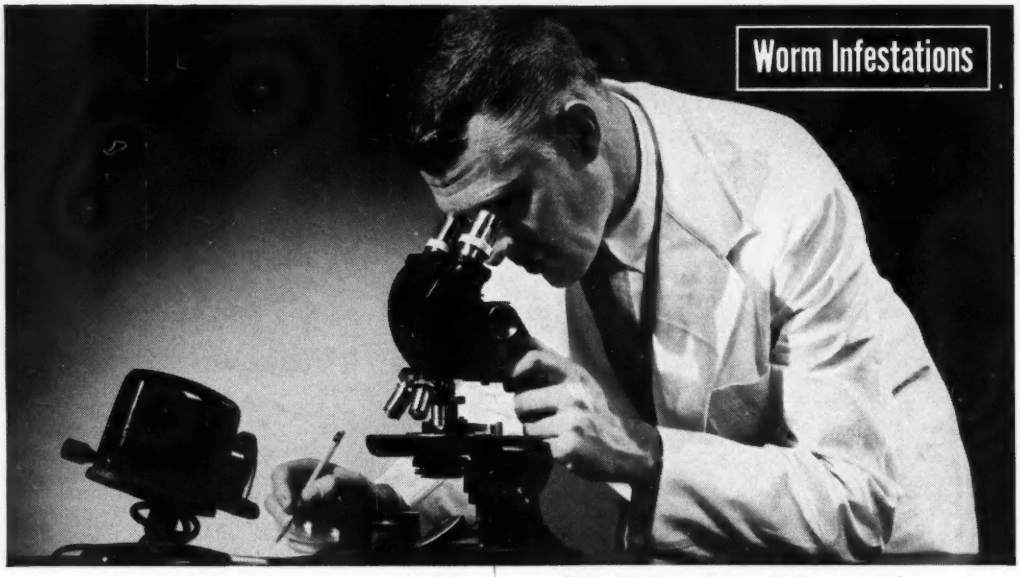

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Psychological Problems of Aging

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SUMMARY

The increasing number of older persons in the United States is having far-reaching economic, social, political and psychological effects. Patients over 60 make up more than a fourth of current admissions to California's state mental hospitals. Biological, personal, cultural and economic problems are present in each elderly person and must be considered in the treatment of such individuals. Neurotic reactions are much more frequent that the psychoses, and these may be treated by the same therapeutic tools utilized with younger persons.

Not all the psychoses in the aged group are such as to necessitate mental hospital care. Many of the patients could be cared for in suitable nursing homes. An adequate mental hygiene program, maintenance of physical health, opportunities for work, and the development of hobby and recreation centers may help ward off many of the difficult problems that the aged now present.

IN this country, in the years just ahead, the average age of the population will increase despite the spurt in the birth rate that has occurred since 1941. The trend toward a population heavily weighted with old people is to be a factor of growing importance in many fields. Old age insurance is to become much more important. Taxes to support the aged and to provide security for other groups will rise sharply. A wave of youths has already begun to flood the schools of the country, starting in the lower grades and extending gradually all through the school system, but the really big wave will be that of persons passing beyond the age of 50 and beyond the age of 65 as the years roll by.

Our total population, which was 106,000,000 in 1920, is now about 141,500,000, and is expected to be 162,000,000 in 1975. The middle-aged group, from 30 to 50 in particular, will increase and will carry the burden of supporting more aged than in the past, and about as many younger people. The number of persons 50 years of age and over has almost doubled since 1920, from 16,000,000 to 31,000,000, and will continue to grow rapidly. It is expected to reach 47,000,000 in 1975. The group of persons aged 65 and over is to be one that will attract more and more attention; there are now 10,500,000 people of that age and there are expected to be 17,500,000 within 25 years. As numbers of old people grow, so will their political power, and with it demands for bigger and better annuities and pensions. All in all, the increase in the number of older persons will have far-reaching economic, social, political and psychological effects.

The problem so far as it affects state mental institutions in California is becoming an increasingly serious one. In 1925, 15 per cent of all patients admitted for the first time to state mental hospitals were over 60 years of age. In 1935 the ratio was 18 per cent; in 1945, 28 per cent. The percentage of patients over 60 years of age in the resident population of the state mental hospitals has increased from 24 in 1936 to 34 in 1945. The more urbanized the community, the higher the rate of admissions to mental hospitals for psychoses of the aged. The rate was 30 to 40 per 100,000 population in 1945 in California. Patients over 60 years of age make up more than a fourth of current admissions to California's state mental hospitals (28 per cent were over 60 years of age, 15 per cent were over 70, and

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6 per cent were over 80). There were approximately 12,000 admissions to the California state mental hospitals in 1948, of which over 3,000 were of persons more than 60 years of age. Of the patients over 60 years of age when admitted, 8.4 per cent die within one month of hospitalization, and 40 per cent within one year. Almost 40 per cent of them, however, are ultimately discharged from the hospital, most of them as improved, indicating that the outlook is not necessarily hopeless and that opportunities for rehabilitation exist.[3]

Aging is a universal, continuous and insidious process, beginning with conception and ending with death. What is understood as "old age" or "growing old," in terms of structure and function, may be observed in one person in his earlier years, and in another many years later; or it may manifest itself locally in special organs such as the heart, kidneys, brain, eyes, ears, or skin, in an extremely irregular and variable fashion. Growth and repair, atrophy and deterioration, are constantly in evidence at any age level and differ in intensity and rate from one person to another so that it becomes most important always to consider biological as well as chronological age. Some persons are old and worn out in adolescence, while others may be old in years and still quite active and useful. Age should, therefore, be considered in terms of structural, physiological, behavioral, intellectual, and emotional factors, and only then can judgments be made of true biological age in contrast to chronological age.

In order to understand any individual, one must understand not only the person but the setting in which he lives. Biological, personal and cultural problems, including sociological and economic problems, are present in every case. This is as true of the oldster as it is of the younger person. The emotional problems of the aged person are, like all psychological problems, those of adaptation to a changing functional equilibrium within him as well as a changing attitude to him from his environment. Old age can be a problem period, characterized by more or less frustration, and special problems of adjustment can arise. All components of human behavior undergo modification as the individual grows older, and any of these changes is a potential source of frustration requiring reestablishment of the equilibrium between needs and satisfactions. Just as the aged in general undergo progressive impairment of the regulatory homeostatic mechanisms which enable the body to maintain a fairly constant internal environment in the face of fluctuating external conditions, in the same way the adaptive capacity of the individual to withstand psychological stress becomes impaired and defenses formerly adequate may disintegrate.

BIOLOGICAL FACTORS

With increasing age, a general reduction in strength, skill, and endurance occurs. This usually causes more difficulty in adaptation in men than women, as it is upon such abilities that the economic independence of the man may depend. Involutional changes, which actually begin early in life, are so subtle and insidious in development that they do not generally manifest themselves overtly until the individual is well past 40 years of age. Disability, while usually gradual in development, may come on abruptly after an illness, an injury, a failure in competition, or after rumination over friendly teasing that "he ain't what he used to be." The oldster in any case may react to decreasing abilities by withdrawal and retreat into a state of rationalizing his dysfunction with complaints of fatigue, weakness, digestive and bowel difficulties and physical illness. Preoccupation with body functions is often the result of decreased activity and leads to feelings of ill health which become an unconscious means of gaining sympathy and attention. Complaints of fatigue are prominent and usually are in inverse relationship to prospects of satisfactions of needs. Instead of withdrawal, the oldster may react to feelings of impending disability by aggressive overcompensation to prove to others he is as good as ever. He may try to increase his effort and productivity beyond his capacity to a degree that he exhausts himself, or his verbal repetitions of his prowess and ability may reach the point of annoyance, or he may adopt vigorous physical culture routines to improve his strength.

In a woman it is the decline in youthful appearance and attractiveness which is more important. She places great store on youth, comeliness and fertility, and their passing is a real personal threat. In contrast to the male, she finds an easy rationalization for this threat in the development of physical illness with a variety of physical complaints, since society's attitude is much more indulgent to illness in the female.

Of important sensory functions, hearing and vision are most often affected by aging. With failing hearing and vision, the oldster becomes deprived of a large share of pleasures, diversions and occupations, and as a result he becomes even more isolated from the activities of his social group. Deafness, in particular, may lead to misinterpretations and misunderstandings, the suspicions isolating him further from his friends and family and making it difficult for him to discharge his social obligations or to function adequately at his job.

The fear of death, present in all of us, is understandably exaggerated in the elderly. Anxiety about living may be translated into anxiety over one's physical health and be expressed in terms of physical symptoms. A fear of ill health, and especially of chronic invalidism, may be constantly present in that such eventualities may be a serious threat to limited funds, force one into a position of dependence on others, or seriously hamper one's activities. Physical health and comfort and emotional security are paramount needs at all age levels, but they become even more essential with advancing years. The younger person has greater hope for recovery when ill and correspondingly less concern about disease, but the older person who is more preoccupied with the state of his health in view of the physical de-

terioration of the aging body, may feel the threat of imminent death.

In the past, tradition has demanded that human beings, as they grow older, should become asexual. But to make such a demand of the aging is as unrealistic as it is to make it of children. While there is generally a reduction in potency in the male and of desire in the female, there is great variability in this. The rate of cessation of gonadal secretion at the time of the menopause may have little, if anything, to do with the onset of so-called "nervous" symptoms at this period of life. Anxiety may become more intense, not because of physiological changes, but because youth is being left behind. Women especially may make frantic efforts to maintain a youthful appearance. The aging male may react to waning potency realistically, accepting it, or he may develop exaggerated, aggressive, or passive reactions. His solution may be a passive one in that he attempts to relieve his sexual tensions by indulging in sexual fantasies or masturbation, and, as a result, his former conflicts at adolescence with associated feelings of guilt and anxiety recur. If he attempts a solution by aggressive means, he increases his overt sexual activities to reassure himself of his sexual competence, and to prove to his spouse that he is still an able man he indulges in extramarital adventures, which sometimes prove very embarrassing. Should he fail, there is apt to follow an intensification of feelings of inadequacy and guilt. He may, instead, attempt to solve his problem by a vicarious interest in the sexual problems of others, condemn the younger generation for their "loose morals," and even join in crusades against supposed evidences of modern depravity.

CULTURAL FACTORS

In order to clearly appreciate the problems of our aging population, they must be considered in the cultural setting in which that portion of the population lived and is now living. Cultural changes, while gradual and continuous, are nevertheless slow enough that prevalent attitudes are in many ways different today than they were in the formative years of our present aged group. This is true of our attitudes about the family group. The family is the most important influence in an individual's personality and behavior. Living in an ideal family group provides the source of many satisfactions — physical care for its members, the sex needs of the individual, need for intimate personal contacts. It provides, moreover, emotional and economic security. Father, mother and children all have certain roles to play in this group, and these may seriously be affected by the aging process. The man has a job to do, daily problems to meet, and the responsibilities of a wage-earner; the woman has the care of home and children; and each is carried along by a pressing daily routine. With increasing age a grave readjustment becomes necessary. The children become adult, marry, and leave the home. Time hangs heavily on the hands of a once busy mother. Illness may interfere with the man's ability to hold a job, or the woman's to be a housekeeper; or the death of a marriage partner may force a major readjustment, especially in living arrangements. The oldster then finds it necessary to relocate himself and to step out of a familiar pattern.

Changes in concepts about the family group have produced problems for the aged. The large family unit consisting of three generations, including grandparents, parents, and children, is a thing of the past. Especially in the urban middle class group, the family is not considered normal unless its membership is confined to parents and children. When children grow up and marry they are expected to leave their parents' home, and as a result the older people are left in comparative loneliness. If one of the parents should die, either son or daughter must add an old member to the family group, which is not designed for such an addition; or else the parent continues with separate living arrangements and increased loneliness.

The attitudes of the younger generation regarding their obligations to the aged are changing, and as a result a great deal of ambivalence and conflict develops. The custom of youngsters', before marriage, turning over their earnings to the parents is disappearing. It is undesirable for the young person to continue his home with his parents after marriage. Newer attitudes about child training have taken from old persons the pleasures of guiding their grandchildren. There is a tendency to treat oldsters with patronizing courtesy, but to exclude them more and more from the social life of the younger group.

So far as living arrangements are concerned, the tendency seems to be for the elderly married couple to maintain an independent household, and for the widowed person to accept living with children or relatives, or in an institutional home, or hotel, or boarding house. With lowered income, the elderly couple often find it necessary to leave the old home to which they are sentimentally attached, to relocate themselves, to leave familiar objects and patterns of living for quarters in neighborhoods of socially inferior rank. The oldster's conservatism resists this change, as familiar objects and persons are important to him. The wife may blame the husband for real or fancied lowering of status; children may assume a changed attitude to impoverished parents; and the oldster may react to his changed status with anxiety, resentment, and somatic complaints. For the woman, the death of a spouse involves economic adjustment and change in living arrangements; for the man, the loss of a homemaker; for either, loneliness and loss of emotional security. When an oldster is forced to move into a child's home, the relationship between parent and child may become reversed, so that the adult offspring now has an opportunity to revenge himself for years of submission to a dominating parent. The elderly man loses the prestige he had in his own home; the woman loses control over domestic arrangements. Each loses status

and prestige. The maladjusted elderly person, like the maladjusted adolescent, may feel unwanted, inferior, unattractive, and unnecessary.

When decrease in family income, decrease in the size of the family group, the death of a family partner, or failing health make existing living arrangements of older persons unfeasible, and one is called upon to advise in such a situation, either in the direction of arranging for the individuals to live independently or to live with children or relatives, one must ask: Does sharing a family home, maintaining a home on a modified scale, living with nonrelatives, or living in an institution, offer the greatest possibilities of satisfaction of the physical and emotional needs of the individuals concerned? Living with one's family may provide natural bonds of affection to incorporate the oldster emotionally into the family unit. On the other hand, the housing of three generations under one roof offers many possibilities of conflict and frustration, each of which must be handled adequately if the group is to live harmoniously. While maintaining an independent household provides lesser opportunities for conflict with younger members of the family, and less loss of prestige and status, it still presents problems of loneliness and of obtaining physical care for illness when it is needed. The institutional family has many advantages of group living, companionship, and provisions for medical and nursing care, but there may be frictions and frustrations among the oldsters with which to cope.

MAKING A LIVING

Opportunity for work is the crux of most problems in the economic sphere, and such opportunity is severely curtailed in old age, especially in times of economic depression. Luckily, older workers usually stand a fair chance of keeping their jobs, although they have a poorer chance of getting new ones. In spite of the fact that older people, in general, have greater difficulty in acquiring new occupational skills, especially when these are in conflict with well established habits, they do have certain assets which come with age—greater evenness of performance, less frequency of errors in performing a well established routine, and less tendency to quit their jobs. Where physical vigor is important, the oldster may be at a disadvantage; where judgment and skill are required, he has the advantage.

Motivation is also an important factor. Strong motivation can compensate for loss of ability, so much so that in a given situation an old person may be more efficient in learning than a younger one. On the other hand, because of personality reactions to environmental pressures from without he may adopt an attitude of helplessness and be unable to use what ability he has. Old people are apt to develop feelings of lack of self-confidence and of personal inferiority. In our present industrial society old age brings lowered productive capacity, decreasing income, increasing need for support from children or social agencies, and a relegation to the status of "has been." It is no wonder, then, that loss of economic independence, especially in an already insecure person, contributes to exaggerated reactions of anxiety, tension, depression and helplessness. What is needed are new purposes and motivations at an age when it is most difficult to acquire them.

RETIREMENT

Retirement too often depends on an arbitrary age limit. Abrupt termination of active interests and occupations can have disastrous effects. The retired person misses the externally imposed routine; he loses familiar landmarks and points of reference, and his own sense of personal identity. Retirement is often treated like a graduation ceremony, with dinners, speeches, and tokens of esteem, but with this difference: The young graduate has his life yet to live; the man who is retired feels too often that he is through, that this is in a sense a funeral ceremony. To the fullest extent, collateral interests should be mobilized and revived and, if necessary, even created. Retirement should always be *from* a job *to* some other interest.

PERSONAL FACTORS

There are a certain number of traits which are attributed to the personality of the oldster which occur with varying frequency and intensity, and which are dependent on the psychobiological integration of the individual. Symptoms commonly appearing in the elderly are feelings of inadequacy feelings of rejection, depression and self-pity, hypo chondriasis, anxiety, irritability, boredom, apathy guilt feelings, social withdrawal, rigidity, and conservatism. Many of these traits can be understood at a psychological level in terms of satisfaction or lack of satisfaction of definite psychological needs. If the oldster's need for physical health and comfort is not satisfied, he reacts with discomfort, pain, irritability and tearfulness; if his need for affection and love is not satisfied, he reacts with feelings of loneliness, rejection and depression; if his need for recognition is not gratified, he reacts with feelings of inferiority and worthlessness; if his need for expression is thwarted, he reacts with restlessness or apathy; and if his need for emotional security is not met, he has symptoms of anxiety.

When an elderly person becomes overly assertive and domineering, it may be a compensatory reaction for feelings of inadequacy, inferiority and insecurity engendered by physical and psychological decline. The feelings of depression may arise from increasing isolation and loneliness as friends and relatives dies, and these added to a loss of self-respect and self-esteem, which follows decreasing status and prestige, enhance the depressive feelings.

NEUROTIC REACTIONS—PROPHYLAXIS AND TREATMENT

Emotional conflicts are as apt to occur in the oldster as they are in the young. He is not in a state of inertia, and as he realizes that lifelong wishes are not attained, old unresolved conflicts may reappear

in the form of passive or aggressive reactions. The patterns of his neurotic reactions are dependent on his premorbid personality and the character of his interpersonal relationships with those about him. Psychological tensions are apt to be translated into somatic tensions, which become attached to specific body organs and provide apparently tangible complaints with which to deal. Illness becomes a means of gaining sympathy and attention, a means of restoring at least some lost security and sometimes provides a method of aggressive domination of the situation by arousing guilt in the child. Anxiety reactions are often repetitions of similar earlier patterns, or they may arise from guilt over sexual fantasies, or from feelings of insecurity, from loss of occupation, loss of prestige, or from being forced into a position of dependency on one's children. As older people become more and more isolated, they may become more and more sensitive to slights, and this may become exaggerated enough to be considered a paranoid reaction. Fatigue complaints are frequent and are in inverse relationship to motivation and prospects of gratification. What is needed in such circumstances is not only rest but a wholesome balance between rest, recreation and work.

The neurotic reactions of the aged are much more frequent than the deteriorative psychoses and are not necessarily signs of organic decay. Syndromes of hypochondriasis, neurasthenic-like reactions, anxiety states, depressions, paranoid reactions and sexually deviate behavior may develop. The same therapeutic tools may be used with the aged as with the younger person.

The level of adjustment made by old people is to some extent the product of their immediate environment and the attitudes to them of the surrounding society, but even more it is the result of the kinds of people they were. This means that the most effective ways to assist the aged are those undertaken before they grow old. Maintaining health, economic security, and the building of a mature flexible character structure are the necessities by which the problems of old age are warded off. Adequate food, lodging, and medical care are necessary for security, but if living is to be adequate in later maturity, an appropriate set of attitudes and a wholesome elastic way of life must be set in early years if later ones are to be contented and satisfying. It is necessary to make preparation early enough that no abrupt disruption of habit patterns occurs. One who does that is able to maintain some degree of personal independence and find sources of gratification in even curtailed activity to such a degree that he maintains status and prestige in his own eyes as well as in those of others.

The oldster should be protected from injury and infection. Food fads should be avoided and his nutritional demands should be satisfied. His sight and hearing should be kept at the best possible acuity in order to avoid increasing his feeling of isolation. Regular physical examinations and measures directed at improving health will help in dissipating fear of invalidism and excessive dependence. An active healthy routine with a definite goal in mind will prevent habit deterioration. The oldster should be encouraged to continue at a job as long as possible and to have suitable interests to replace it when he is retired. He should be discouraged from believing he is wise just because of his age, and from interfering in the lives of his children, even if the children are making a "mess of things."

The psychotherapy of older people is not as hopeless as many think; a fatalistic attitude is unnecessary. One principle of therapy is to give them a chance to talk about themselves and their problems. Respectful attention and interest, not maudlin sympathy, is what they want. The therapist must recognize the oldster's need for physical and emotional security and for independence. He must give the patient an opportunity to work out his own solutions and not impose prejudices upon him. Moreover, it must be recognized that such a patient still has capacities for growth and change. An old person does not lose his personality and individuality just because he is old.

One of the most serious problems with which a therapist is faced is that of unsatisfactory relationships within the family group consisting of two or three generations. The problems in parent-child relationships in old age are as serious as those in childhood, except that the oldster constitutes the problem child in this case. If a child refuses to help a parent, either because it would disrupt his own family or because of overt hostility, the refusal is apt to engender severe conflict and guilt feelings in the child, and these must be worked through to some sort of solution. The kind of living arrangement best suited for an elderly person is dependent on the individual needs, physical and emotional, of that person. For one patient it may be an independent home; for another, full institutional care. Such a decision cannot be made lightly. Where the oldster presents a cultural problem, every effort should be made to fit him into a group with cultural background similar to his own, lest his already existent isolation will be exaggerated. Like the rest of us, the oldster needs provision for his physical health and comfort, affection from those about him, recognition of his abilities and limitations, some means for self-expression in work or play, and economic and emotional security.

PSYCHOSES OF THE AGED

The primary presenile dementias include such disorders as Alzheimer's and Pick's disease, but not every organic brain disease beginning in the presenile period is one of these syndromes. Only after such disorders as cerebral arteriosclerosis, cerebral syphilis, intracranial tumors and post-traumatic conditions and other possible specific causes have been ruled out may a diagnosis of Pick's or Alzheimer's disease be considered. The differentiation between the two is academic but may be made by a pneumoencephalographic examination through demonstration of the circumscribed cortical atrophy of Pick's

disease or the more diffuse atrophy of Alzheimer's disease.

Senile psychosis and psychosis with cerebral arteriosclerosis are the commonest causes for admission of aged persons to state mental institutions in California. In the majority of cases there is evidence only of simple deterioration, but depressed and agitated, paranoid, presbyophrenic (confusion, disorientation, memory defects, and confabulation) and delirious reactions may occur. The depressed patients may respond quite favorably to electroconvulsive therapy so far as the affective components are concerned, but the substratum of intellectual impairment which is the result of permanent organic damage will remain unchanged. This must always be kept in mind when outlining the prognosis for such patients. Recent work on the role of large molecule lipoproteins in atherosclerosis offers possibilities for prophylaxis and perhaps of treatment for the atherosclerotic lesions so commonly appearing in the elderly.[1]

It has become increasingly evident that organic changes alone are not sufficient to explain the symptoms of these psychoses. The severity of mental symptoms does not necessarily parallel the extent of the cerebral lesions. Aged persons, apparently normal mentally until death, at autopsy may be shown to have changes in the brain as severe as or more severe than those observed in postmortem examination of patients with obvious senile and arteriosclerotic psychoses. It must be remembered, too, that even in organic psychoses like these, premorbid personality integration and situational stresses may play important roles in the mental illness. When it becomes necessary to hospitalize a patient who has one of the psychoses of the aged, the guilt feelings of children must be appropriately handled.

Delirious reactions in senile and arteriosclerotic individuals often occur and frequently go unrecognized. Etiological factors such as the injudicious use of drugs, especially barbiturates, infectious diseases, metabolic disorders such as uremia, diabetes, pernicious anemia and vitamin deficiencies, and posttraumatic conditions should be kept in mind constantly. The syndrome of clouding of consciousness, fear and apprehension and bizarre illusions, hallucinations and delusions may be superimposed on an already damaged nervous system and should be clearly recognized as delirium. In treatment, restraint of the patient should be avoided. If drugs are ordered, the judicious use of paraldehyde is recommended rather than barbiturates. Continuous bath or sedative packs should be ordered for sedation, and special efforts should be directed at combating dehydration and keeping up salt intake. The administration of glucose, insulin and vitamins is frequently indicated. Most delirious patients are frightened. Since they tend to misinterpret various stimuli, the source of stimuli should be reduced to a minimum. A reassuring nurse, familiar persons and surroundings may help more in quieting a delirious patient than any sedation.

MENTAL HYGIENE

The following is the author's digest of the discussion among the members of the Section on Problems of the Aged at the Governor's Conference on Mental Health.[2]

1. An adequate mental hygiene program, leveled at educating the public about the medical and psychological needs and problems associated with the aging process, is very important. Such education should begin in the schools and continue throughout adult life. Young people are not generally well motivated toward studying the problems of advancing maturity since the problems have not yet become personal to them. Education should be leveled first at the group in which the problem is real: the elderly people themselves, and the friends and relatives who find it necessary to deal with them. The general public should realize the large number of aged in our population, and appreciate that they desire some share of attention, just as children and adolescents do. Physicians, nurses, attendants, and social workers all need education along these lines. Until recently, many physicians have shown little interest in the chronic disease problem, and just as there has been developed an increasing interest in the psychological aspects of disease in general, so can an interest in the psychological problems of the aging process be developed with appropriate education. All facilities of the state, including the county departments of welfare, the State Department of Public Health, and other agencies of the state government, should foster and encourage the organization of local agencies in the community to carry on this educational program. Mental hygiene societies, adult education classes, parent-teacher association groups, community chest organizations, churches, etc., should be asked to assume responsibility to give all the necessary encouragement to such a program, emphasizing the importance of the individual's assuming responsibility himself about the problems of aging to the extent to which it is possible for him to assume it. The family and relatives of sick elderly people are very important in this problem. They are intimately involved, emotionally and practically, since nursing care often falls to them, particularly to the woman in the family group. They need guidance and support and opportunities to ventilate their anxieties.

2. Every available facility, private and public, should be made available to all for the maintenance of physical health and the repair of physical defects before they become pronounced handicaps to mental health. This is considered of prime necessity, and should be part and parcel of a general public health program at both private and public levels.

3. In the economic sphere, opportunity for work is the crux of most of the problems on a financial level for the aged person. It is generally agreed that chronological and arbitrary age limits forcing people into retirement are not the best method of approach, but government, as well as industry, is often

guilty of such an attitude. Industry feels that it is in business to make a profit, and that if the elderly person is more of a handicap than an asset in the industry, it is not fair to burden such an industry with him. There is also the very real problem that such a person with a physical or mental handicap may constitute an industrial hazard for which the company is responsible and liable, and under the present law such liabilities cannot be waived. There is at present no obvious solution to these problems. Further research and investigation are indicated to produce ways and means by which to set up standards to base retirement on a person's general physical and mental condition rather than on calendar age alone. This should apply to government as well as to industry.

4. Those people who, because of physical or mental handicaps, are unable to work, and those people who are looking forward in the near future to retirement, should be encouraged to develop hobbies and interests to take up their time, and communities should be encouraged on private and public levels to develop facilities for recreation, social intercourse, education, and hobby training for the older age group. Such a center in San Francisco is proving extremely popular and beneficial. Use of the adult education departments in hobby training, already popular in metropolitan communities like San Francisco and Los Angeles, should be extended to other localities in the state. Such a program would do a great deal to dissipate feelings of loneliness and isolation, and might help to solve some of the psychosomatic problems presented by the elderly.

5. Throughout the state, especially in the metropolitan communities, there have sprung up many so-called family style boarding homes which are licensed by the state as "foster homes for the aged." For elderly people who are well enough to live in such a group, and who have the financial means to do so, this may prove an ideal solution for a limited number of the elderly in that they still adhere to some sense of independence. So long as they have opportunities for appropriate care and treatment of physical and mental ills, either from private sources if they can afford it, or public facilities if they cannot, such a program would undoubtedly do a great deal in keeping many of the homeless aged from being committed to large custodial institutions. It is important that aged persons living in such groups have facilities for recreation, education and hobby training available. It is important, too, that people in charge of such family style boarding homes be educated, if necessary by the state, as to the physical and psychological needs of the elderly group.

6. A detailed study should be made of the advantages of developing a so-called "home care" program similar to that which has been developed at Montefiore Hospital, New York City, for the care of patients who have chronic diseases of various kinds. In such a program the home is treated as if it were an extension of the hospital environment. Opportunities are provided for the patient who lives at home to get medical care, visiting nurse services, housekeeping services, transportation, occupational therapy, and social service. Not only could this be a saving in hospital costs, but, even more important, some patients who do poorly in the hospital may respond dramatically well in the environment of sympathetic and affectionate care in their own homes if they are surrounded by attentive relatives. This would require careful social service investigation to be certain that such a program could be successful, and it could be only where there is close rapport between the family and the patient. It would require that the members of such a family needing guidance and support could have opportunities to ventilate their anxieties to physicians or social workers. It is recognized that the majority of elderly people do not need hospital care, and that a large group of them who are now being hospitalized might not require it under such a program.

7. For persons who have early signs of mental deterioration but who are still not so sick physically or mentally that hospital care is necessary, and who, because of various emotional involvements cannot be cared for in their own homes by their own relatives, foster homes might be found with the aid, if needed, of social workers through public or private agencies. Such social workers should be considered part of a therapeutic team, together with the nurse and physician, and should be concerned with the treatment of patients on psychological and environmental levels. There should be enough of them that all their time is not taken up solely with the question of eligibility and they should be of a quality to be able to assume the responsibility of appropriate treatment at a social work level.

8. If more medical and psychiatric diagnostic and treatment services could be made available in physicians' offices, or in the out-patient clinics of general hospitals, many of the patients who are at present being hospitalized might be treated on an out-patient basis for long periods before hospitalization became necessary. This would, of course, be much better and cheaper than expensive hospital care, but for communities in which such facilities are not available, the organization of traveling clinics would be necessary.

9. Elderly patients requiring hospitalization for physical or mental handicaps should not be isolated in institutional homes for the aged, although those could provide, in appropriate cases, advantages of group living and opportunities for medical and nursing care, especially if such homes were geared to individual needs. Such an institution should be built with a majority of its rooms single ones, rather than composed of large wards, to give the patients a modicum of privacy.

10. The wisdom of sending the majority of patients with senile and arteriosclerotic psychoses to state mental institutions, most of which are situated many miles away from the homes of patients, is questioned. The dislocation of an elderly person from his home and family often does much to has-

ten deterioration and early demise. The move from home to general hospital, to county psychopathic ward, to state mental institution is upsetting even to a young person, but more so to the elderly who depend so much for the satisfaction of their needs on familiar objects, people and surroundings. Voluntary public and private hospitals should be enlarged when funds and building facilities become available to provide units adjacent to the general hospital, and these units should contain a proportionate number of beds reserved for patients with the physical and mental problems of old age. The majority of these patients do not of necessity require mental hospital care in the ordinary sense. The depressed and dangerously paranoid could be committed to mental institutions; but for those whose problems are essentially those of physical and mental deterioration, appropriate general medical care is the prime necessity. Patients who were located in treatment units adjacent to large general hospitals could be more easily visited by their relatives, and they could be made part of a general rehabilitation program directed at the problems of chronic diseases in general. This would serve also an educational purpose in enhancing the interest of visiting physicians and young resident physicians in training. If such a program is carried out, and the burden of care of elderly mentally ill patients is removed from the state institutions to the county level, it is assumed that financial assistance should be provided by the state to approved hospitals in proportion to the services rendered. In those counties which would not have facilities to care for such patients, arrangements could be made on a cooperative basis with adjacent counties which had appropriate facilities.

Such a program would give us a good start in helping solve some of the problems presented by an increasingly large elderly group and it should help relieve the heavy burden on the state mental institutions for the care of many patients who require for the most part adequate medical nursing care.

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The Non-Group Subscriber—A Blue Shield Problem

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SUMMARY

The basis of prepaid voluntary medical insurance is to provide adequate medical service with the most inexpensive premium rate that is actuarially sound. This has been accomplished up to date by group enrollment. However, this does not provide for enrollment of a large number of insurable persons who are not members of groups. Experience with non-group subscribers to United Medical Service, New York, is discussed and suggestions are made for simple, inexpensive means of enrollment and premium payments.

THE proponents of a compulsory health program are wont to declare that the Blue Shield plans do not provide equal opportunity for enrollment of individuals who cannot be covered by group enrollment.

The problem of non-group enrollment in Blue Shield Plans is a challenge and demands a solution. In the development of Blue Shield Plans it was imperative that attention should be mainly directed to the acquisition of groups. Group enrollment gave the maximum actuarial security with a minimum of constant effort. In non-group enrollment satisfactory actuarial results were to be obtained on many occasions only by trial and error. In the beginning it was frankly acknowledged that a very large percentage of our population could not be enrolled on any group basis. The non-group subscribers fall into three separate and distinct categories:

1. *The Group Conversion Direct Payment Subscribers*

The subscribers in this category were originally group subscribers and their subscription charges were paid through the group. When these subscribers leave their respective groups they have the privilege of converting to a direct payment basis by paying the subscription charges directly on a quarterly, semi-annual or annual basis. From an underwriting point of view the experience with this conversion class is naturally poor by reason of the fact that only a relatively small percentage of all those who leave groups continue on a direct payment basis. United Medical Service, New York, lost about 50 per cent of the subscribers who left a group and did not convert. This 50 per cent ratio of cancellations resulted in loading the non-group enrollment against the company. It was fair to assume that the 50 per cent group conversion direct payment subscribers who converted anticipated the need for medical service and therefore converted to direct non-group payments. Experience with this group was not satisfactory.

2. *The Group Direct Payment Subscribers*

The subscribers in this category are primarily enrolled as part of a direct payment group. Theoretically, they are a group but for a variety of reasons it is impossible to obtain a group remittance. Therefore, the subscriber must personally make an individual remittance from the commencement of his enrollment. Subscribers of this class are enrolled just like those of any other group and must meet the regular group enrollment underwriting requirements. The enrollment must meet the established percentages but the subscribers do not have to provide health statements. Inasmuch as subscribers of this class make individual payments from the effective dates of their coverage, there are no group conversion subscribers from this category of business. When a group direct payment subscriber leaves the group through which he was originally enrolled, he merely continues to make his payments directly as he did while he was in the group. The experience for this class of business is generally good, due to the fact that the enrollment in the first instance must meet established enrollment underwriting requirements, and also due to the fact that these people are accustomed to making individual remittances from the beginning of their contract and therefore have a personal interest in their coverage.

3. *The Miscellaneous Direct Payment Subscribers*

The subscribers in this category cannot enroll through groups, either on a group remittance or on a group direct payment basis. They must submit a health statement which, after being screened, is individually underwritten. The experience with this type of business is generally good because the contracts written do not provide for maternity coverage and because the risks are individually underwritten. Inasmuch as photostatic copies of the applications made by such subscribers are attached to the contracts issued, such contracts are subject to cancellation in the event that subsequent developments indicate that false statements were made in the application. Obviously, it is more expensive to process direct payment subscriptions than group remittance subscriptions, largely because direct payment subscriptions are individually handled. However, it is a clear-cut operation and can be recommended to

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any plan, as it affords many subscribers opportunity for securing protection which is not otherwise available to them.

The historical background of the development of the non-group subscriptions is interesting and, like all experience based upon trial and error, was productive of much enlightenment. For real community coverage there must be some provision for individual or non-group enrollment. The Associated Hospital Service of New York was the first plan in a large city to write miscellaneous or non-group enrollment.

The Associated Hospital Service had permitted the formation of miscellaneous groups of ten which were, in effect, nothing other than groups of ten persons who desired coverage. There was no common denominator as obtains in groups formed from the employees of the same employer. In addition to self-formed groups of ten, there were community groups under which persons individually filed applications which were held by the plan until it had on hand a theoretical community group consisting of a specified number of applications. The experience under this quasi-group enrollment was so unsatisfactory that Associated Hospital Service was compelled to cancel the contracts of some 200,000 subscribers who had been enrolled without bona fide group relationship.

Following the cancellation of the contracts Associated Hospital Service offered the subscribers opportunity to apply for reenrollment subject to a detailed application containing questions intended to bring out the past medical history and the present condition of health and any adverse underwriting factors. In view of the extraordinary losses for maternity care under the former non-group enrollment, Associated Hospital Service did not continue maternity benefits under the new non-group enrollment. The practice of omitting maternity benefits on non-group enrollment has continued to date. The fact that maternity benefits are not provided under these contracts presumably has had no damaging effect on public acceptance, as is indicated by the steady growth of this class of business. Under Associated Hospital Service there are now nearly 250,000 non-group subscribers; under United Medical Service nearly 100,000 non-group subscribers. Further indication of public acceptance is the fact that the annual rate of cancellation of contracts under non-group enrollment is lower than under any other class of enrollment.

These changes were highly successful, and Mr. Louis Pink, chairman of the board of directors of Associated Hospital Service, could report that non-group enrollment in Associated Hospital Service was encouraged in 1944 as a public service, so that self-employed persons, and others without group affiliations, would not be deprived of protection against hospital costs. Age limits were raised from 60 to 65 to enable older persons to join. (From fewer than 40,000 non-group members in 1944, Associated Hospital Service reached a total of some 240,000 non-group subscribers by the end of 1950.)

Persons who are self-employed or employed where there are too few employees to form a satisfactory group should by all means be provided with an opportunity to obtain Blue Shield protection. Blue Shield certainly cannot fulfill its proper destiny unless its protection is made available to all insurable members of the community.

The problem is vital both to Blue Shield and to Blue Cross plans. At present in the New York area served by Blue Shield and Blue Cross, groups are formed where there are at least four employees in an organization. If there are fewer than four employees, individuals are eligible for coverage on a non-group basis after filing an application containing all pertinent medical information and certifying that the applicant is in good health.

Experience has proved that individual enrollment can be established on a sound basis. Certain safeguards, of course, must be established in order to achieve a proper selection of risk, and this invariably involves at least a statement of health and previous medical history and careful examination of the application before acceptance. It is also necessary to indicate that the contract issued in such cases cannot include protection for maternity service because there appears to be no way to obviate services above cost if maternity benefits are included. Obviously, a healthy young couple who desire to raise a family would quickly embrace an opportunity to enroll if maternity service was provided, and in reasonable time a claim would be created. Waiting periods of 10 or 12 months are not sufficient deterrents or obstacles to prevent adverse experience. Nevertheless, Blue Shield protection can be made available for all other causes requiring medical care and involving hospital admission so as to make the plan sufficiently attractive to those who seek protection against medical costs.

In claim administration, claims of non-group subscribers are scrutinized much more carefully than those of group subscribers in view of the representations of good health at the time of enrollment. It has been found necessary to rescind contracts if there is evidence of misrepresentation in the application at the time of enrollment.

All Blue Shield plans must study and analyze the experience with very small groups. It is probable that a tabulation of results will demonstrate a very high claim ratio and raise a question as to the wisdom of accepting these risks, regardless of the waiver of known and preexisting conditions, without adequate screening-controlled enrollment.

In contrast, the successful experience with the non-group direct payment category can be accounted for in part by the careful screening based upon individual medical history reports. It might be in the better interest of all concerned if enrollments in the smaller groups were screened in the same fashion. Properly handled, non-group enrollment can be a safe risk for a medical care plan, and at the same time provide coverage for many people who are not eligible for group enrollment. United Medical Service has found, however, that it is not possible to

offer unrestricted non-group enrollment because too often it attracts only those who need immediate medical care.

United Medical Service limits non-group enrollment to people under the age of 65 who are self-employed, such as shopkeepers and professional men; those who are not employed, such as widowed or divorced housewives; and those who are employed where there are fewer than four employees. Maternity benefits are not given to non-group enrollees. Waiting periods — six months for removal of tonsils and adenoids and 11 months for treatment of preexisting conditions — are also a consideration because they are imposed on all but large groups with a high percentage of enrollment. The United Medical Service non-group application form includes questions about the medical history of the applicant and his family dependents for the past five years. Between 11 per cent and 13 per cent of the non-group applications received are rejected—usually because of the medical histories. People who have had recent hospital care, especially in connection with surgical treatment, are frequently told to apply again at a later date. A few applicants are taken upon waiver of care for very specific ailments.

The non-group application is photostated and becomes a part of the contract. The right is reserved to rescind contracts within a two-year period if there is any evidence of fraud. Rarely are contracts rescinded for that reason, but when they are, all subscription dues are returned.

To keep the rate structure as simple and fair as possible the non-group subscriber is charged a premium rate higher than that charged group subscribers but exactly the same as the rate for members who leave a group and continue membership on a direct payment basis. These rates average about 23 per cent more than the group enrollment rate. Because of the difference in premium rates, the formation of groups has been greatly stimulated.

Michigan Medical Service has been carrying on at stated intervals a community enrollment drive for non-group subscribers. The net result of these campaigns shows that about 3 per cent of the residents subscribed for the non-group plan and another 3 per cent subscribed to group plans during the community drive. These intensified periodic efforts required at least two months of preparation and were very expensive; at one time the cost for each such enrollment was five dollars. In addition, the combined loss ratio of the Michigan Hospital Service and the Michigan Medical Service was a little over 100 per cent.

The community enrollment drive is in pronounced contrast to the procedure followed by United Medical Service (New York), which handles all such business through correspondence. U.M.S. sales representatives are not expected to seek non-group enrollment and no sales production records are maintained to give credit to a salesman who may have occasion to bring in one of these applications. Enrollment inquiry cards and literature with respect to non-group enrollment are included with certain mailings from the U.M.S. office. Inquiry cards and literature are also available in doctors' offices and in hospitals. Through these sources non-group enrollment is consistently increasing—at a minimum of acquisition expense. During the year 1950 the gain in U.M.S. non-group enrollment was nearly 20,000 subscribers.

At present, most Blue Shield plans are dubious about individual non-group enrollment. While they recognize the vast number of potential subscribers in non-group enrollment, they have been afraid that the premium rates will not sustain the over-all cost.

Most Blue Shield plans require non-group subscribers to make quarterly payments instead of monthly payments as under group enrollment. Quarterly payments are more painful than monthly payments, particularly for persons in low income groups without reserve funds from which to make them. In addition, billing and collections by the usual orthodox means are expensive procedures.

A number of conferences were held with the Greater New York Savings Banks Association to consider ways and means of having non-group subscribers go to the nearest savings bank and pay premiums monthly. Out of the conferences came a plan by which payment could be made very easily by giving the subscriber a premium book consisting of 12 pages—one page for each month. Each page would be composed of three identical coupons. The bank would give one of the coupons to the subscriber as a receipt, send one to the company, and hold one for its record. There would be many advantages in such a system. The bank would get additional deposits and make contact with potential customers. As most subscribers would have easy access to a neighborhood bank, payments could be made monthly without much effort. The medical care plan would save the cost of billing for and collecting premiums from non-group subscribers.

Dr. Hannah, medical director of the medical care plan operating in Toronto, has perhaps pioneered in having payment of monthly premiums made at any of several banks in the territory. After several years of experience, he reported that there was an insignificant delinquency of payments by subscribers in this category.

One of the advantages of making non-group enrollment available is that it offers an excellent basis of obtaining knowledge of where potential groups exist in the community. When a medical care plan offers a non-group enrollment it invites everyone in the community to seek enrollment and to answer requests for information concerning employment status. From such inquiries the plan is then in a position to learn where there are potential groups and to take proper steps to enroll them. An interest expressed by the inquirer thus leads to greater enrollment and if group enrollment is not possible the protection of the plan may still be offered to the applicant. U.M.S. has at all times been careful to see that non-group enrollment does not compete with group business. The backbone of Blue Cross and Blue Shield business is group business. If non-group

applications were accepted from persons who could be enrolled through groups at their places of employment, the management of the firm for the group might not continue its support. Similarly, the management might deny U.M.S. the privilege of organizing a group; employees might be told to apply individually on a non-group basis.

Experience has indicated that if an applicant is employed in a group where group enrollment is possible, then enrollment should be obtained only on the basis of a group. Not until all means of obtaining group enrollment have been exhausted should consideration be given to providing non-group enrollment.

The request for non-group enrollment for persons employed where there are a sufficient number of employees to form a group in most cases represents the most effective sources of group enrollment. In replying to such an inquiry, the advantages of group enrollment are stressed and the applicant invited to make his interest known to his employer. The plan can then immediately contact the employer, stating that interest has been expressed among his employees. It is at this point that the sales effort for group enrollment begins and, when properly applied, more often than not results in the enrollment of not one person but a group of persons. Consequently, when employers become aware that only through their cooperation and participation can their employees obtain the protection of the plan, then the group effort becomes easier and the enrollment is achieved on a more satisfactory basis both from the actuarial point of view and from the point of view of more stable and continued enrollment of those who are in greatest need of Blue Shield protection. The social objective, the solvency and the usefulness of any Blue Shield plan rest upon the integrity and character of all who participate in its activity—the public, the subscribers, the physicians and the plan. One discipline must be rigorously enforced by every voluntary prepayment medical plan —that the promises of services must never exceed the ability to pay for them.

The caption "Prepayment Insurance" is no magic sesame. It opens no doors to wealth. It creates no money. No voluntary prepayment medical plan should promise more than the premium rate will sustain. Premium or insurance money does not buy more than any other money in the market. In fact, at present its purchasing power is diminishing rapidly and the continuance of the inflationary spiral will seriously interfere with the premium rate structure of all Blue Shield plans. The solvency of Blue Shield plans must not be maintained at the expense of the quality of service or by infringement upon the fair remuneration to the physicians rendering the services. Medical service means adequate remuneration to the physician so that all concerned are relatively satisfied. It is well to remember that cash indemnity insurance provides only dollars to pay for medical service but it does not provide medical service. Nearly 72 per cent of the total enrollment of all Blue Shield plans is held by plans offering service benefits.

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Cortisone in Treatment of Bronchial Asthma

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SUMMARY

Twenty patients with intractable asthma were treated with cortisone on various dosage schedules. Results indicated that a rapid improvement in the asthmatic state may be expected in four to five days with high level dosage of the hormone—usually a total dose exceeding 200 mg. per day at the beginning. If treatment is discontinued after a week, relapse usually will occur within a period of eight days. If small doses are given two or three times weekly, following initial response, relapse may not occur for 20 or 30 days. The interspersed administration of ACTH during an attempt to discontinue cortisone apparently was of no value. It therefore appears that cortisone control of intractable asthma is dependent on large dosage until clinical improvement is obtained, then approximately 100 mg. two or three times a week for maintenance of a reasonable state of health.

THE advent of cortisone or Compound E and its physiologic progenitor, adrenocorticotropic hormone (ACTH) has offered possibilities in the therapeutic management of bronchial asthma. It has been demonstrated that both these substances are capable of protecting the shock organs, the lungs, against the antigen-antibody reaction which is responsible for the clinical manifestations of the hypersensitive state.[2] It should be emphasized that there is no clear-cut evidence that asthma can be considered, in any sense, a deficiency disease; that is, that there is any adrenocortical insufficiency other than that series of changes in the adrenal cortex which is usually associated with the exhaustion phase of the alarm reaction. The summation of experience so far would indicate rather that the administration of cortisone or ACTH creates an altered state[3] in which the phenomena of hypersensitivity are absent.

This altered state consists of a number of changes in the body, especially in electrolyte metabolism, but affecting also many other phases of body chemistry and physiology. The most important, in relation to the problem at hand, is the tendency towards sodium retention with its effect particularly on the cardiovascular system in long-standing asthma complicated by emphysema. Potassium and chloride loss also occur during the administration of therapeutic doses of cortisone and ACTH; this may be compensated by administration of oral potassium chloride. Hypertension has also been noted; it may be either transient or prolonged. A diabetic state has also been observed in the course of therapy. Following treatment, a state of mild cortical depression has been noted, manifested largely by weakness and decrease in the excretion of 17-ketosteroids in the urine. Recovery from this state is usually complete.[3]

Part of the material (Cortone®) used in this study was supplied through the courtesy of Dr. A. A. Gibson, Medical Director of Merck & Co. Inc.

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CLINICAL MATERIAL

The present report is based upon a study of 20 patients with bronchial asthma who were treated with cortisone by intramuscular injection. The patients ranged in age from 16 to 86 years. No patients in the pre-puberty period were accepted because of the possibility of endocrine disturbance precipitated by cortisone therapy. All of the 20 patients during a period of observation before treatment were found to have asthma which recurred at least once daily, and the history as obtained from the patients indicated the occurrence of daily episodes with no periods of well-being, and no periods in which the asthma had been less than moderately severe. For the purposes of this discussion, the asthma is graded as follows: Zero indicates no wheezing, either objective or subjective; one plus indicates wheezing which requires no medication; two plus, wheezing which responds to oral medication, usually one of the ephedrine compounds; three plus, asthma which requires either epinephrine by hypodermic administration or by spray; four plus, asthma which is not responsive to epinephrine or which relapses within a few moments after epinephrine administration. Throughout the period of observation of all patients the grading of asthma has been carried out on this basis. The grading has been, as far as possible, entirely objective, and based essentially on need for and response to medication during the preceding period of 24 to 72 hours.

METHOD AND DOSAGE

Treatment was given in essentially five different ways. One group of four patients was treated intensively for a period of one week, and then retreated after relapse. A second group of seven patients received one week of intensive therapy, followed by decreasing low-level maintenance therapy. A third group, four patients from Group 2, was retreated at high levels of therapy and was given intermittent doses of ACTH during an attempt at tapering off. A fourth group of nine patients received one week of intensive therapy, followed by high-level maintenance therapy. Three of the patients in the fourth group were taken from one or

another of the preceding groups after relapse. A fifth group of three patients received mid-level therapy throughout. High-level therapy is defined as daily doses in excess of 150 mg.; mid-level therapy as daily or less frequent doses not exceeding 150 mg. and usually 100 mg.; low-level therapy as less than 100 mg. in any day, usually 50 mg. daily or less often.

Group 1. Short Intensive Treatment.

Among the four patients who received one week of intensive therapy, which was then discontinued, all had complete relief of asthma for periods of one, three, five and 30 days. Relapse occurred at the end of the periods indicated, but in no instance was the disease then as severe as it had been before therapy. Re-treatment in the same manner in all these cases resulted again in improvement, but of less pronounced degree than that obtained with the first course of treatment. Although it is possible that this was because the patients may have lost some faith in this "magic compound," subsequent observations indicated that this phenomenon was probably based on the activity of cortisone rather than on a psychogenic factor.

Group 2. Intensive Therapy and Low-Level Maintenance.

Seven patients who received intensive therapy for a week and subsequently were given small tapering doses of cortisone, usually in amounts of 50 mg. two or three times weekly, had the same rapid response as the first group with almost complete disappearance of asthma within a four- to five-day period. Remissions in this group lasted for 12, 14, 21, 21, 25, 30 and 35 days before relapse occurred.

Group 3. ACTH During Discontinuance.

At a later date four of the patients from Group 2, who had had control with high-level dosage, were given ACTH alternating with the maintenance doses of cortisone. This procedure did not materially delay relapse, which occurred after 15, 21 and 30 days in three patients. The fourth did not have relapse after 60 days, but in this case the previous history indicated that the asthma would have stopped spontaneously at about the same date that treatment was stopped.

The relapse in two of the patients in Group 2 was as severe as the asthma before treatment, and for a time these patients appeared to be resistant to increased doses of cortisone.*

One of the patients in this group who was given increasing doses supplemented by Mercuhydrin® finally responded for a second time, but not to the same extent as to the first course. Improvement at the one plus and two plus level then persisted for 30 days, when an additional period of increased dosage was necessary to get the patient back to a one plus level. In the other case, that of a 16-year-old boy, the disease appeared to be totally resistant to the cortisone, whereupon it was stopped for a period of 12 days. During that time it was necessary to hospitalize the patient three times to control extremely severe status asthmaticus by giving fluids intravenously — epinephrine, aminophylline and iodides. After 12 days without cortisone, there was excellent response to a new period of intensive therapy with complete disappearance of asthma for 15 days, followed by a mild relapse when an effort was made to discontinue the cortisone after several doses of ACTH. Subsequently, the condition of the patient was well stabilized with a dosage of 100 mg. three times weekly. This patient was the only one in the series in whom "moon face" and severe acne developed, and both of these manifestations of cortisone activity receded as treatment continued.

Two other patients in this group responded satisfactorily to increased doses of cortisone, and in them the disease subsequently remained at a zero to one plus level for 30 and 40 days with dosage of 100 mg. two or three times weekly. The remaining three patients did not resume treatment, since the very severe status for which treatment had been initiated did not recur over periods of 14, 55 and 64 days, although all of them had partial relapse.

Group 4. Intensive Treatment and Mid-Level Maintenance.

The additional six patients who received one week of intensive therapy, followed by prolonged administration of mid-level maintenance doses for four to six weeks, had rapid regression of asthma to a zero or one plus level within four to five days. At the time of this report they had not had relapse. In three cases even mid-level dosage was discontinued and relapse had not occurred after 14, 40 and 60 days. In the cases in which maintenance dosage was continued, there was no evidence of any of the undesirable secondary effects of cortisone therapy.

Group 5. Mid-Level Therapy.

In three cases in which there was pronounced emphysema and suspicion of cor pulmonale, only mid-level therapy was given throughout. It induced improvement or disappearance of wheezing respiration by the end of the second week. Clinical improvement was not as dramatic as in the other groups, but in the fourth week all the patients were improved.

RESULTS IN RELATION TO DURATION OF ASTHMA

In seven of the 20 cases the history was such as to indicate that the asthma could be expected to be self-limiting in its course, although at the time of

* There are various possibilities to explain an increase of symptoms during adequate cortisone dosage. The first and most obvious is an increase in the causative factors initiating the asthma. The second, which was encountered in three patients, is an increase coincidental with evidence of increased tracheobronchial infection. This condition responded satisfactorily to adequate antibiotic therapy. A third possibility is that of allergic reaction to the cortisone. This was not encountered in this series as far as can be determined. The fourth explanation of increased symptoms, described here and observed in three patients, is based on the association of increased skin puffiness with increased symptoms of asthma. Electrolyte studies at these times showed no significant changes in the blood levels, but the response to mercurial diuretics suggested that local fluid retention, based on electrolyte changes not reflected in the blood studies, formed the basis for the clinical changes.

treatment it was resistant to all other forms of therapy. Six of the seven patients with disease of that order had sufficient improvement to permit discontinuance of cortisone, and in all of them the disease was less severe than it had been before cortisone was given. Three were relatively free of asthma after 14, 40 and 60 days, and three had one plus and two plus attacks. The seventh patient had almost immediate relapse on cessation of treatment.

Thirteen of the patients had asthma which, according to the history, had been intractable for more than two years, and there was nothing in the history that would indicate that the disease would regress spontaneously. In order to keep the asthmatic state in these patients at levels from zero to two plus cortisone therapy had to be continued at a level of not less than 100 mg. two to three times weekly for periods of from three weeks to three months, with periodic increases in the dose to compensate for temporary exacerbations. In all cases some degree of relapse occurred within eight days of any attempt to stop treatment completely.

LATE EFFECTS OF CORTISONE

Because treatment was not continued over long periods in this series, it was not possible to determine the maximum period of therapy to which a patient may be subjected without irreversible changes[2] in adrenocortical function, in the endocrine system in general, or in other phases of body metabolism which are affected by cortisone. At the time of report there was no evidence of irreversible changes of that nature.[3]

There was some hope at the beginning of this study that over a period of time the continued use of these substances might result in improvement of the organism's ability to control bronchial asthma. Except for the improvement that usually follows prolonged symptomatic control of asthma, there was no evidence that such a change had taken place. There is reason to believe that adrenocortical depression occurs in patients given cortisone and that it persists for some time after cessation of therapy.[3] In the cases in which ACTH was given while the dosage of cortisone was being tapered off, Thorn tests stimulated no response in the circulating eosinophils up to four days after the last injection of cortisone.

CASE REPORTS

CASE 1: The patient, a 22-year-old male, had had intractable asthma since childhood. For a year previous to treatment he had been using an epinephrine spray, supplemented by injections of epinephrine at least once or twice daily. Injections of cortisone were given each day for seven days, beginning with a total dose of 300 mg. the first day, followed by two injections of 200 mg. and then four of 100 mg. By the third day of treatment the patient was entirely free of asthma and remained so for a period of five days. During this time the vital capacity rose from 3,200 cc. to 4,800 cc., with an improvement in the expiratory rate. Ten days after the beginning of therapy, asthma recurred at a two plus level and by the 22nd day had reached a three plus level. At that point retreatment was initiated upon the same schedule used in the first course of treatment. After five days the asthmatic state was at a one plus level. The subsequent course was one of gradual increase of asthma, until finally it was stabilized at a three plus level. Although the patient was somewhat better than before treatment, the therapeutic result was no better than with other successful methods of symptomatic therapy of asthma. However, the five-day response in which the patient was entirely free of asthma was extremely dramatic and fairly characteristic of the initial response to cortisone therapy.

* * *

CASE 2: A 16-year-old boy with intractable asthma since infancy was in severe status asthmaticus when high-level treatment was started. By the fifth day, the degree of asthma was one plus, and by the seventh day the patient was essentially free of asthma. He remained quite well, except for occasional mild wheezing, for a period of 18 days while receiving small, relatively widely spaced doses of cortisone, the dose not exceeding 50 mg. at any time. After 20 days a relapse began and it was not allayed despite use of moderately increased doses of cortisone. Three admissions to hospital were necessary, and finally when moon face and severe acne developed, cortisone was discontinued. (In light of what is now known of cortisone therapy, it might have been better to increase the dose to a much higher level at that time.) As the patient appeared liable to die of asthma during the third hospital admission, it was decided that despite the side effects more cortisone would have to be given, since there seemed to be no other way of obtaining remission. High-level therapy was started again on the 53rd day, and again a striking response was observed. Asthma completely disappeared on the sixth day of treatment. Cortisone was then continued at levels of 75 mg. to 100 mg. daily. The time between injections was gradually increased and they were interspersed with injections of ACTH in the hope of stimulating the depressed adrenal cortex. This was unsuccessful and on the 91st day relatively high-level treatment was again initiated and there was fairly good response, with remission to the one plus level and finally to zero level after 11 days. The asthma then was quite adequately controlled, except for occasional episodes of two plus asthma, by giving injections of 100 mg. every two or three days.

* * *

CASE 3: A man 49 years of age with severe asthma had very much the same response as the patient in Case 2—at the beginning, dramatic response to cortisone, followed by a relapse in 26 days; the relapse finally controlled by increased doses of cortisone; a second relapse shortly afterward when an effort was made to discontinue treatment by spreading out the injections of cortisone; recontrol of the asthma by increased doses of cortisone; and again the failure of interspersed doses of ACTH to prevent relapse when cortisone was discontinued.

* * *

CASE 4: A 69-year-old woman with three plus asthma had temporary and satisfactory response to hospitalization and symptomatic treatment, but there was rapid relapse after only a few days. Cortisone was given and by the fifth day there was remission of asthma to one plus, and for 26 days the patient remained well while receiving small doses of cortisone, at first 100 mg., then 50 mg., and finally 25 mg. twice a week. Gradual relapse to a three plus level occurred and increased doses of cortisone were given. The asthma cleared completely on the seventh day of increased dosage. As in the other cases, an attempt to withdraw cortisone by injections of ACTH failed and it was necessary to resume the twice or thrice weekly injections of 100 mg. of

cortisone in order to control the asthma. With the exception of occasional episodes the patient had been in good health for more than 60 days at the time this report was prepared.

CONCLUSIONS

1. Cortisone is useful in controlling prolonged periods of asthma which are resistant to other forms of therapy, and in which the history indicates that the asthma may be self-limiting.

2. In chronic intractable asthma cortisone has a beneficial effect on the asthmatic state, but prolonged administration for periods up to three months does not result in sufficient change in the basic pattern of the asthma to permit discontinuance of therapy without some degree of almost immediate relapse. The relapse usually is not as severe as the disease was before treatment.

3. Since prolonged relief of previously intractable asthma may be effected, it might be well to initiate, during the remission, other forms of therapy of a more definitive nature.

4. Cortisone may have a useful role in temporary control of asthma during medical and surgical emergencies which may arise in the life of the patient.

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Anal Infections Encountered in General Practice

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SUMMARY

Thoroughness in study of the anorectal canal to the ten-inch level serves to detect infectious lesions in that area in the incipient state and thus preclude the debilitating and destructive chain of events which follows when early treatment is delayed. The technical requisites of the routine examination are not beyond the scope of physicians in general practice, who can prevent many of the chronic and disabling complications by early diagnosis.

THE sum of all the discomfort caused by infectious lesions of the anal region and by complications arising from them, merely because symptomatic treatment was begun without resort to any sort of regional examination, would form a sad aggregate. This melancholy figure is all the more distressing in light of the fact that 85 per cent of anorectal disease can be diagnosed by inspection, palpation, and anoscopic examination. It is as incumbent upon a physician in general practice as upon any other to examine at least within the range of the naked eye and the gloved finger. He ought to be conversant with the various etiologic factors concerned in the development of infections in the anal region, the avenues by which such infections invade the adjacent tissues, the clinical symptoms resulting therefrom, the objective evidence to be noted on inspection, palpation, and anoscopic examination, the use of this evidence in differential diagnosis, and some therapeutic indications and practices.

ETIOLOGIC CONSIDERATIONS

The basic fact underlying all anal infections is the invasion by pathogenic bacteria of anal ducts and glands and regional tissues. The fecal material is funneled into the crypt (Figure 1), and in some circumstances—local trauma, for instance, may open a route—bacteria invade the anal ducts and glands. Invasion of the regional ducts may occur if they are obstructed and the glands are distended to the point of rupture. It is also possible that such invasion occurs indirectly by lymphatic avenues. The role of the crypt, duct, and gland system in the pathogenesis of anorectal disease was investigated and reported by the author and his associates[1, 2] (Figure 2). Nesselrod[4] illustrated the crypt orifices which

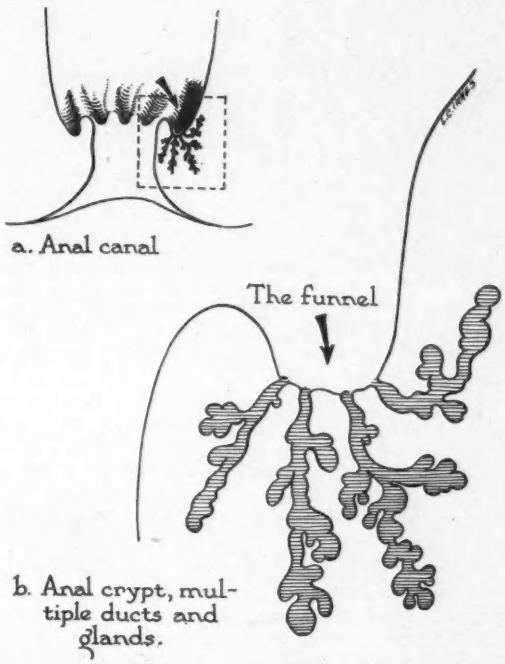

Figure 1. — Diagrammatic representation of the anal canal and crypt with "funnel" relationship to contiguous ducts and glands. (Modified from Nesselrod's textbook, "Proctology in General Practice," 1950.)

he believed served as "funnels" by which infection is guided into anal ducts and glands. It is now generally accepted that these glands play an important part in the genesis of infectious anorectal lesions, although all the possible intermediary processes are not fully known.

The clinical application of the transmission of infection through the system of anal glands (Figure 3) is one of correlation of microscopic changes which follow the various successive steps in the development of the disease process with the consequent clinical manifestations. Microscopic investigation confirms the impression that localized cellulitis involving duct and gland structures constitutes an early stage in the process. In the first place, involvement of the contiguous tissues is usually one of direct invasion following the more or less definite microscopic channel of anal glands, which, according to the previously mentioned investigation by the author and his associates, showed a wide individual variation, not only as to the number of glands present, but also as to their location and the depth of penetration. It is also possible that the spread of

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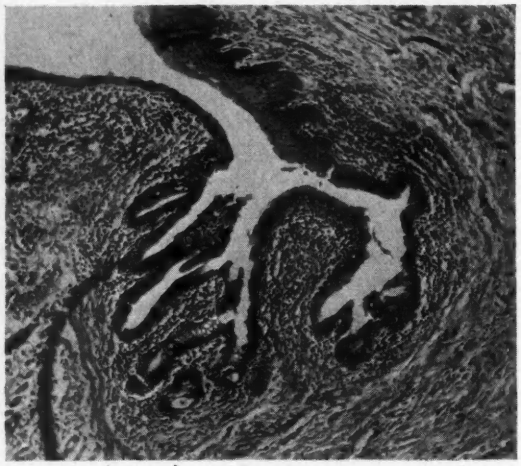

Figure 2.—Enlarged deep crypt with numerous ramifying anal glands. Lymphocytes are infiltrated around the mucus-producing glands. Hematoxylin- and eosin-stained; reduced from a photomicrograph with a magnification of 73 diameters. (Hill, J.A.M.A., March 1943.)

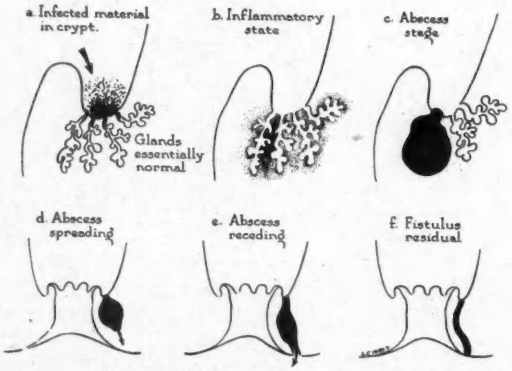

Figure 3.—Diagrammatic representation of pathogenesis of anal infection with resultant abscess and fistulous residual. (Modified from Nesselrod's textbook, "Proctology in General Practice," 1950.)

infection to these tissues is metastatic in nature—that infection is carried indirectly by way of lymphatic channels and blood vessels.

In diagnosis, anorectal inflammatory disease (Figure 4), by virtue of the complexity of etiologic patterns, cannot be considered a single disease. Furthermore, it may be manifest in more than one form in the same patient. For convenience, infectious anorectal disease can be grouped into two classes, direct and indirect, the classification depending upon the avenue of infection. Classified as direct disease are fissure-in-ano, abscess, and fistulous disease. Those of indirect origin include hypertrophy of anal papillae and contracture or stenosis of the anus.

Hemorrhoids, essentially a plexus of varicose veins surrounding the anorectal outlet, occur at a site of anastomosis of vessels of the systemic and portal circulation. As they are in close relationship with the anal ducts and glands, they are vulnerable to infection through supporting tissues. Then, secondarily, periphlebitis and phlebitis of these varicose elements produce acute swelling, capillary congestion and rupture, resulting in both extravascular and intravascular thrombosis — the so-called "strangulated hemorrhoid." A self-limited manifestation of this process is the single or multiple external thrombotic hemorrhoid.

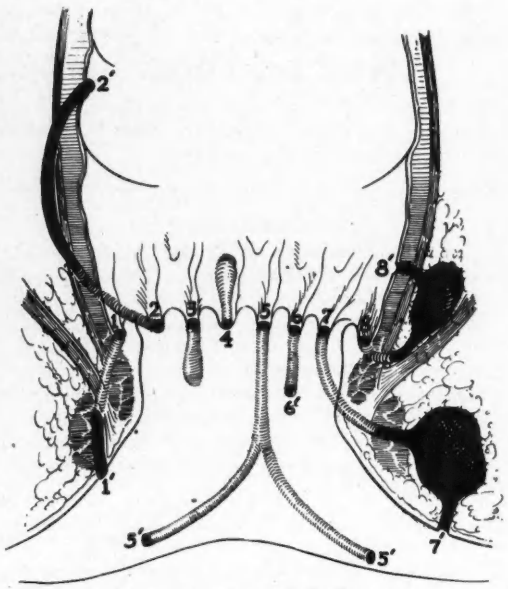

Figure 4.—Diagrammatic representation of the anorectal canal showing the variable pattern of spread of infection from the crypt line. Complete fistulas: 1, 2, 5, 6, 7, 8, primary openings; 1', 2', 5', 6', 7', 8', secondary openings. Sinus formation with possible fissure and ulcer formation: 3 and 4 respectively. Abscess: ischiorectal 7-7', supralevator 8-8'. (Modified from Nesselrod's textbook, "Proctology in General Practice," 1950.)

SYMPTOMS REFERABLE TO ANAL INFECTION

Even though a patient have symptoms of rectal disease only, complete history-taking and thorough physical examination must be routine. Study of a rectal disorder should never be so concentrated that the possibility of disease elsewhere in the body is overlooked. The cardinal symptoms of anorectal disease are alteration in bowel habits, pain, bleeding, swelling, purulent discharge, and loss of weight.

Alteration in bowel habit of organic origin may be caused by either infection or new growth. The size, shape, consistency, and color of stool must be correlated with this cardinal symptom. Ease and completeness of evacuation and the presence of protrusion or prolapse of tissue mass are related factors. It sometimes happens that change in bowel habit is attributed to functional disorder even in cases in which evidence of organic disease is observable by adequate visual examination.

Bleeding may arise from a lesion anywhere in the

intestinal tract. The appearance of fresh blood suggests the presence of bleeding in the lower colon, rectum, or anus. Blood which is bright red in nature and drips or spatters in the toilet basin or is observed on the toilet tissue more commonly is either from an anorectal lesion of infectious origin or hemorrhoids. But a physician should not conclude this to be so without adequate visual examination including anoscopic and sigmoidoscopic procedures.

Pain incident to anorectal inflammation is usually localized and is usually a dull aching or throbbing, bearing-down sensation. Acute anorectal pain which causes a patient promptly to consult a physician suggests ulceration, infection, or thrombosis of the regional vessels as the most likely cause.

Swelling of acute progressive type with pain, malaise, possible elevation of temperature, and leukocytosis indicates abscess formation. On the other hand, the sudden formation of a focal swelling with stinging sensation and pain about the anal margin indicates hemorrhoidal thrombosis, which may be associated with regional infection.

Discharge of a purulent character from the anus and anal margin, while sometimes incident to malignancy of contiguous tissues, is more commonly consequent to fistulous disease. On the other hand, persistent soiling of the parts may be a consequence of anal operation or perineal laceration, or it may be caused by lymphopathia venereum, condylomata, prolapsing hemorrhoids, and pruritus ani.

Loss of weight may accompany chronic infectious disease of the anorectal region, including chronic ulcerative colitis and fistulous disease associated with lymphopathia venereum.

EXAMINATION ROUTINE

A routine examination need not be a complicated procedure. This should consist of inspection, palpation, and anoscopic observation with the patient in the right or left Sims's position, followed by sigmoidoscopic visual observation to the ten-inch (25 cm.) level. In covering the present subject, only the first three steps will be described in detail. The necessary clothing having been loosened or removed, the patient is placed in the left Sims's position and properly draped. The preliminary application of a topical anesthetic in water-soluble lubricant to the anal canal and low mucosal surfaces will not only facilitate in routine procedure, but will also permit a satisfactory study of the most painful lesions. This anesthetic may be applied by the nursing attendant several minutes before examination. The lower bowel surfaces are cleansed two hours before examination by use of saline enema until water returns clear.

Inspection of the buttocks and of the sacral and perineal areas should be done first, then examination of the anus carried out. This is facilitated by having the patient bear down, thus disclosing any abnormalities. When skin tags or external hemorrhoids are present they appear as a deformity on the anal margin and are indicative of anal disease. Hypertrophied skin folds suggest the occurrence of pruritus ani. Fissure-in-ano or painful ulcer is commonly accompanied by an edematous skin fold or formation of a sentinel pile. The presence of draining skin sinuses is indicative of a fistulous process which commonly follows the formation of an abscess. A condyloma is essentially an infected area of hyperplastic perianal skin. Sebaceous cysts usually cause little or no inconvenience. Pilonidal sinuses, usually situated in the sacrococcygeal region, are the result of an embryonic rest of epithelial tissue.

In palpation of the perineal tissues, infiltrating or cord-like processes extending into the anal margin may be felt. Extreme sphincter spasm is indicative of anal disease and may be the result of a focus of infection in crypts, ducts and glands. Contracture and stenosis of the anal canal and consequent alteration of bowel habit may be the ultimate result of persistent infection. Gentleness is a prerequisite in palpation and digital examination. The finger should be well lubricated. If pain, spasm or stenosis is present, palpation should be done with the small finger rather than the index finger. By comparison with the corresponding areas of the opposite side, small focal lesions may be more definitely identified. After the perianal, perineal and sacral areas have been palpated, the finger is approximated to the anus and the volar surface pressed against the sphincter ring. The bevel of the finger should follow the lateral wall of the anal canal. The finger is introduced downward and forward toward the umbilicus through the anal canal and sphincter ani. Bidigital examination (using the index finger and thumb) aids in outlining the anus, anal canal, and other areas in question. The lower Houston valves, as well as the seminal vesicles and the prostate gland in males and pelvic organs in females can be easily reached by the palpating finger. By having the patient bear down during palpation, it is possible to outline the rectosigmoid junction in many instances. Perianal abscess, thrombosis of the regional veins, ulcer depressions, or pathologic change in the perirectal glands of Gerota may also be identified. With infections of the perianal and perineal structures, palpation of the bilateral inguinal chain of nodes should be practiced.

Anoscopic examination under direct or indirect lighting is best accomplished by using an open-end anoscope with a removable obturator. This technique has been described elsewhere.[3] The anoscope, well lubricated, is introduced into the anal canal as gentle pressure with the beveled edge of the obturator is maintained against the lateral wall. The instrument should be directed forward toward the umbilicus through the sphincter ani. After the obturator is removed, observation is made of the regional mucous membrane surfaces, crypt line, and anal canal. This is best accomplished by having the patient strain and bear down, as in defecating, as each area is observed. Thus the presence of hypertrophied anal papillae, which may assume a polypoid appearance, can be noted. Localized gland, duct, and crypt infection is also verified under vis-

ual observation by expressing purulent exudate from the crypt orifice with the margin of the scope. The primary opening of a fistula also may be detected, and in many instances this impression may be confirmed by gentle probing. Fissure formation is observed more commonly in the posterior commissure. Fissure may be accompanied by edematous hypertrophy of an anal papilla on its upper margin as well as a sentinel pile at the anocutaneous line.

DIFFERENTIAL DIAGNOSIS

Even with the most ideal office examination, it is impossible to estimate fully the magnitude of all the infective processes involving the anorectal canal. The final analysis in every extremely painful condition is examination under regional anesthesia in the operating room where surgical treatment can be carried out as indicated.

Pruritus ani, a symptom-complex with many varied causative factors, presents findings in many instances in which local anal infective disease must be correlated. Funnel infection through ducts, glands, and contiguous tissues certainly bears indirect if not direct etiologic relationship in the spread of infection to epidermal structures. Soiling from prolapsing hemorrhoids, together with the attendant moisture and discharge from fissure formation, abscess, and fistulous disease may also cause pruritus.

Infectious pyodermia or hidradenitis suppurativa involving the perianal cutaneous surfaces is characterized by tunneling and sinus formation with the joining of superficial abscesses involving integumental areas where the apocrine sweat glands predominate. This process, however, does not involve the duct gland system.

Pilonidal cyst and sinuses, considered as a differential diagnostic problem, must be viewed with their possible association with abscess and fistula formation involving the posterior anal margin. A direct continuity occasionally exists between these two lesions in the same person.

Hemorrhoidal varicosities with attendant edema and swelling accompanying variable degrees of acute thrombosis at times is difficult clinically to differentiate from acute inflammatory disease with abscess formation. It is important that an exact diagnosis be established, under regional anesthesia if necessary, to prevent invasion and destruction of tissue from an unsuspected infective process.

THERAPEUTIC CONSIDERATIONS

The treatment of anal infection calls first of all for early, adequate and complete diagnostic evaluation. Simple, self-limited or superficial lesions only are amenable to office treatment; patients with other lesions should be hospitalized. Adequate relaxation, produced preferably by regional anesthesia consisting of low spinal or caudal-transacral block, permits the examining physician to determine the extent of spread of the infectious process.

Fissurectomy call for the surgical removal of the ulcer-bearing area including subcutaneous gland-bearing tissues, associated crypts and ducts, hypertrophic anal papillae together with associated varicosity, and sentinel pile formation external to the lesion with wide drainage onto the skin margin. Partial posterior sphincterotomy relieves sphincter spasm postoperatively. It is also the surgical treatment for contracture and stenosis accompanying chronic infection originating in crypt, duct, or gland. A counterpart of this disease, characterized by growth of fibrous replacement tissue (and in some centers called pectinosis) is merely a manifestation of infectious process. Muscle incision relieves hyperplasia or bar (Blaisdel's) formation of the superficial portion of the external sphincter ani.

In dealing with the treatment of abscess formation about the anorectal canal, it should be borne in mind that the longer a fulminating infection is allowed to exist, the greater the likelihood of attendant destruction and breakdown of tissue. As this may entail irreparable damage to muscle structure, the virtues of early surgical drainage are evident. Unfortunately, sedation, denver mud or poultice therapy is still the procedure of choice by many clinicians who prefer to wait for a pointing and spontaneous evacuation of purulent exudate, and others have hoped that injection of antibiotic agents would prevent the spread of the infectious process as well as remove its cause.

Early incision and drainage of an abscess in the anorectal region calls for T-shaped or elliptical incisions paralleling and cutting the muscle structures. This is followed by scalping of the abscess with wide saucerization and bevelling of skin edges. Breaking up of all loculi and dependant drainage are final requisites. This procedure essentially makes a complete fistula, producing the secondary or external opening to the diseased process. In certain instances it is feasible to remove the primary opening at the same time by doing a first stage or complete fistulectomy. Mucosal abscesses are preferably opened with a cautery, with bevelling of edges, excision of secondary fistulous processes and dependant drainage to the anal margin. Use of rubber tissue drainage and avoidance of gauze packing minimizes pain and is adequate if surgical draining has been complete. In all cases of proven fistulous abscess, as soon as infection has been allayed by incision and drainage the patient should be advised to have complete fistulectomy promptly.

Fistulous disease manifests itself in a varied pattern and is classified accordingly. The primary opening is usually associated with the opening or orifice of an anal crypt. A through-and-through communication from this primary opening externally, submucosally, or to another organ is a complete fistula. A blind tract ending subcutaneously or submucosally is an incomplete fistula or sinus. The process may be multiple, forming varied patterns with attending residual abscesses. Tuberculosis and malignancy may attend this chronic infectious process. Biopsy of any suspicious tissue is mandatory.

The treatment of fistula-in-ano is primarily surgical. This includes the removal of the entire diseased process consisting of primary and secondary openings and the communicating tracts. The crypt, duct and gland elements related to the primary opening and original spread of the disease should also be resected. As the chief complication of the surgical treatment of this disease is incontinence, sphincteric preservation and restoration are important factors. The type and extent of the fistulous disease may indicate the use of multiple stage procedures.

Wide surgical and dependent drainage is paramount. Enlarged papillae and adjacent hemorrhoidal varicosity must be removed to permit uniform healing. All sphincter muscle fibers must be cut at right angles to the line of cleavage. The placing of a seton about a muscle bundle so as to allow for the healing of large excavating wounds is a preliminary step to a secondary procedure with a second stage incision of the sphincter and removal of the seton. This permits the residual shallow groove to heal progressively.

1212 Wilshire Boulevard.

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Antihistamine in the Prevention of Serum Reaction Following Injection of Tetanus Antitoxin

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SUMMARY

Of 100 patients given tetanus antitoxin, 56 were given an antihistaminic drug in oral doses of 50 mg. daily for ten days following injection. The other 44 were not given antihistamine. The incidence of serum reaction in the former group was 3.6 per cent; in the latter, 20.4 per cent.

THE use of tetanus antitoxin in certain types of injuries has become almost as obligatory as the use of x-ray examination in cases of suspected bone injuries. Reports in the literature indicate that about 25 per cent of all patients receiving tetanus antitoxin have serum reaction of one kind or another, either early or late, generalized or local. All such reactions are annoying; some are serious enough to require hospitalization. The possibility that serum reaction might occur has resulted in an understandable reluctance on the part of some physicians to use tetanus antitoxin prophylactically.

A study was carried out to determine what effect, if any, the giving of antihistaminic drugs might have on the incidence of such reactions. The records of 100 patients who had received injections of tetanus antitoxin in the office were reviewed. All had received 5,000 units of tetanus antitoxin after negative reaction to a skin test for sensitivity to the material. Of the 100 patients, 56 had received, in addition, 50 mg. of Pyribenzamine® orally each day for ten days following the injection. Data on the incidence and severity of reactions in both groups are given in Table 1. As is indicated in the table, in no instance did reaction occur within 24 hours. This may be because routinely 0.3 cc. of epinephrine hydrochloride 1:1,000 was added to the antitoxin in the syringe.

810 South Spring Street.

TABLE 1.—*Incidence of Serum Reaction Following Tetanus Antitoxin Injections Among Patients Not Given Antihistaminic Drug Compared with Incidence Among Patients Who Were Given the Drug.*

44 patients not given antihistaminic drug:

Character of Reaction	Immediate or Within 24 hours	Delayed	Per Cent
General	0	5*	
Local	0	4	
	0	9	20.4

56 patients given antihistaminic drug:

Character of Reaction	Immediate or Within 24 hours	Delayed	Per Cent
General	0	0	
Local	0	2	
	0	2	3.6

*Reaction was severe in four cases; hospitalization was required in two.

The Organization and Operation of a Study of Diarrheal Disease in Fresno County

WM. F. STEIN, M.D., *Fresno;* M. DORTHY BECK and ARTHUR C. HOLLISTER, JR., M.D., *Berkeley,* and EARL MORTENSON, *Fresno*

SUMMARY

The procedures used in the organization and operation of a special study on diarrheal diseases involving federal, state, and local agencies are outlined. The integration of such a project into a local routine program is discussed and the possible benefits derived by the various agencies are briefly evaluated.

APPLIED epidemiologic research has been carried on for many years by the State Department of Public Health, metropolitan health departments, the universities, and the United States Public Health Service. However, such work by federal, state, and university groups has usually been independent in nature because of the requirements of specialized personnel, time, equipment, working space, etc., as well as the difficulty of fitting these projects into routine local programs. The purpose of this report is to illustrate how and to what extent, both from an administrative and from an operational standpoint, a special project was integrated into the Fresno County Health Department program.

PROJECT PROPOSAL

For a period of at least five years previous to this study the infant mortality rate from diarrhea and enteritis was consistently higher in San Joaquin Valley counties than in the state as a whole and programs were generally directed toward this problem by the local health departments.

In the fall of 1949, the incidence of diarrheal diseases among migratory workers' families reached a climax. It was difficult to know the exact numbers affected, but a general measure is that during the summer and fall the hospitals were crowded with very young children sick with this disease. Through the local health departments and hospitals, specific and more detailed information became available which demonstrated the magnitude of the problem in morbidity and mortality, particularly among the infants.

When the urgency of the situation became apparent, various conferences were called, federal, state, and local agencies participating. Discussions were held not only on general health matters, but also on sanitary facilities, housing, nutrition, the fly problem, and related subjects. The need for a basic epidemiologic study of the diarrheal diseases in the Central Valley was recognized as fundamental from the recommendations proposed. As part of such a study, surveys on the domestic fly population would be included because flies are considered one of the problems in the transmission of these diseases.

Since the focus of the diarrheal diseases was located in the San Joaquin Valley, the first study was planned for that area. However, because of the magnitude of the problem, and, because this was to be a pilot study, the area surveyed was of necessity limited. Fresno County was selected, as it fulfilled the major requirements for such an investigation. There were available adequate sampling populations in migratory labor camps, in low socio-economic groups, and in substandard housing; the county was centrally located and was representative of the San Joaquin Valley.

The project was planned as a cooperative effort by the United States Public Health Service, the State Department of Public Health, and the County of Fresno. Each agency contributed personnel, facilities, and financial support in varying combinations. By joint agreement, Dr. James Watt* of the United States Public Health Service was appointed project head and the staff was organized under his direction. The plan was to operate the field survey for a period of six months (July-December 1950).

For convenience, the investigation was divided into two phases, the human epidemiologic study, and the fly population study.

The main objectives of the human study were:

1. To determine the incidence of diarrheal diseases in general population groups by using the method of single or repeated family unit histories in a selected sample.

2. To determine the prevalence of the most common etiologic agents causing diarrheal diseases—Shigella and Salmonella micro-organisms — by the method of obtaining rectal swab cultures on all children ten years of age and under in general population groups, without reference to clinical illness.

The main objective of the fly study was to determine, if possible, whether a correlation existed between the incidence of diarrheal diseases and the domestic fly population. Evaluation of the fly popu-

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The work here reported was a joint project of Fresno County Health Department, California State Department of Public Health, and the Federal Security Agency, Public Health Service, National Institutes of Health, Diarrheal Disease Control Service.

Presented before the Section on Public Health at the 80th Annual Session of the California Medical Association, May 13-16, 1951, Los Angeles.

*Medical Director in Charge, Dysentery Control Studies, National Institutes of Health.

lation was accomplished by taking grill counts of sample blocks to establish a population index, and by the use of the fly trap to determine the type of flies in the selected study areas.

A combined objective of the two phases was to plan and design an environmental sanitation survey form to effectively evaluate the sanitation as it might apply to the epidemiologic factors of diarrheal diseases and the production of flies.

ROLE OF THE LOCAL HEALTH DEPARTMENT

The Fresno County Health Department assisted in developing the specific project proposal as outlined. At first, it seemed an overwhelming task with a shortage of personnel, of funds, and of working space. However, with continued group discussions of the various interested agencies, the plans developed and the project began to unfold as a tangible working organization. The program was presented and explained to the Fresno County Board of Supervisors,† who consented to assume sponsorship. The special study became known as the Diarrheal Disease Project of the Fresno County Health Department. All financial transactions relative to the study were conducted by the county.

Following these preliminary steps, two storage rooms in the basement of the local health department building were converted into a field station. Some equipment was provided locally, and some obtained from the State Department of Public Health. The rest was purchased out of the special fund. Full-time personnel for the unit consisted of civil service employees from federal, state and county agencies, and temporary employees hired only for the project. The temporary employees were cleared through the county civil service, and emergency ratings with new titles were set up in specific cases. The services of other regular county employees—such as public health nurses, bacteriologists, and sanitarians—were contributed as time permitted from their routine duties. The utilization of local personnel on a study of this kind — applied epidemiologic research — as usually conducted by either federal or state agencies, is a definite departure in California.

The operation of the project, assisted by federal and state plans and personnel, was integrated into the County Health Department program in every possible way. The County Health Officer was consulted on all matters of local policy and he served as liaison between the head of the project and the board of supervisors. The public health nurses' assistance to the study cannot be overemphasized. First, in the survey work, they became part of the field team. In addition, each public health nurse selected a group of interested citizens in some one locality (town, housing project, or camp) in her district and developed them into a voluntary working unit. Such community health committees were an organization mechanism which had been used successfully in other public programs in Fresno County. They helped the public health nurse to carry out her part in the Special Diarrheal Disease Project. (It was planned that these committees would, in addition, be part of the local health department's long-range program to develop citizen awareness of problems and citizen participation in solving these problems.) Just as the individual public health nurses became part of the field team, so did the members of the community health committees under their guidance. In other words, extra personnel was provided and used effectively in a number of instances; undoubtedly, many more locations were surveyed because of this citizen participation.

To further integrate the activities into the local program, field visits were scheduled as far as possible to coincide with local health department functions. For example, immunization clinics were utilized whenever feasible—the public health nurse and the field team synchronizing the two operations to the best advantage. Child health conferences were routinely visited, and medical members of the Special Project worked with the public health nurses in obtaining rectal swab cultures from the children and family histories on those attending the conference.

A description of the scope of the survey operations will indicate to some extent the physical effort and work involved and the process of integration used in this investigation. The two phases of the epidemiologic study paralleled each other as far as was practical, although they were operated separately.

The human study included four types of population groups of various socio-economic levels. Briefly, these may be described as follows:

1. The child health conference groups were well-baby clinics, and partially represented a cross-section of the population of the town in which they were held. Thirteen of the 17 organized conferences were visited from one to three times each during the six-month period.

2. Housing project occupants were population groups living in government housing facilities. These were located in urban and suburban areas. The incomes of these people varied considerably, but the housing was quite modern and the units fairly comparable one to another.

3. "Fringe" areas of towns selected were suburban areas adjacent to city limits, having rural facilities such as well-water, privies, and sub-standard housing.

4. Labor camps were cabins, tents, or trailer space furnished by the farm owner and used for the housing of farm labor during the crop season.

These four population groups were from widely separated representative areas of Fresno County, including urban, suburban, and rural. The field teams travelled an average of 2,000 to 3,000 miles each month in carrying out the surveys in these scattered locations.

According to the primary objectives of the human study, family histories were to be obtained to determine the incidence of diarrheal disease. Single his-

†The City of Fresno contracts with Fresno County for Health Department services.

tories were taken on approximately 2,000 family units. In several selected areas, history-taking was repeated monthly to observe the seasonal trend; this represented approximately another 2,000 histories. Public health nurses and community health committees assisted in taking many of these histories. It is impossible to estimate the number of home visits required to carry out this objective because many additional visits were necessary to find the parents at home. Also, extra visits were made when information was incomplete.

The second main objective was to determine the prevalence of Shigella and Salmonella microorganisms. A total of 7,065 rectal swabs from children under 10 years of age were collected. Again, the public health nurse and her committee were of definite assistance. Because they were known in the community, many times they paved the way for admission into the home. Also, as an employee of the local health department, the public health nurse could act as liaison for the field team, and in many instances made the preliminary arrangements in the community or camp for the survey.

The division of laboratories of the Fresno County Health Department became an important adjunct to the laboratory phase of the project. The staff assisted in setting up the physical arrangements in the field laboratory and supervised the installation of certain equipment, and throughout the survey accepted the responsibility of its maintenance. The laboratory division further cooperated with the Special Project by screening all organisms isolated by the field laboratory which were suspected of belonging to the genus Shigella or Salmonella. Approximately 900 cultures were screened by biochemical and agglutination tests during the period of operation. The final definitive typing of the organisms was done at the State Division of Laboratories.

The scope of the domestic fly study included the evaluation of the fly population in three of the four economic divisions of the human study — housing projects, "fringe" areas of towns, and labor camps. Each area was sampled once a week from June to October, and thus a weekly fly population index was established for that period. The sanitarians of the Fresno County Health Department were most helpful in assisting the field team in setting up fly sampling areas; they also cooperated in developing the survey form used to evaluate objectively the existing sanitation in the labor camps.

The coordinating mechanism utilized in the Special Project included staff and general meetings, progress reports, and consultative service. Each week, the head of the Special Project attended the public health nurses' staff meeting. Plans and problems of the project as they related to this group were presented and discussed, and the schedule for survey activities for the following week was outlined. Any suggestions or changes for survey areas were made by the public health nurses at this time. Consultative service was given by the head of the project to the public health nurses in developing the community health committees. In fact, he and other members of his staff attended meetings and helped to interest the citizen groups in the formation and function of these community committees. Another means of further coordination was to keep all agencies currently informed on the survey activities. At the nurses' staff meetings, verbal progress reports were made. In addition, a written monthly report was submitted and each agency received a copy.

Consultative service was given to the chief sanitarian and his staff, and at group conferences basic sanitation as a control measure for diarrheal diseases was stressed repeatedly. Also discussed was the development of a sanitary survey code which might be applicable not only in the present investigation, but also for the long-range health department program in this field. In-service training was furnished by the group conducting the fly study; the sanitarians were given field training in the techniques used by the entomologic field team.

Meetings were held with the board of supervisors, the Interagency Committee,* and the San Joaquin Valley Health Officers' Association. These groups were apprised of the situation and of the progress of the investigation, and were informed regarding possible control measures. For general interest, some publicity on the operation of the project was released to the citizens of Fresno County through their newspapers and the radio.

EVALUATION

There is no doubt that each agency involved profited from the coordinated effort required to organize and operate the Diarrheal Disease Project. The exact benefits derived are difficult to evaluate, but appear to be twofold: First, the immediate gain of working as an integrated group of three agencies; second, the potential long-range effect on the general program of the local health department resulting from the multiple underlying factors of the specific diarrheal disease problem.

With regard to the immediate benefits referred to, state and federal agencies now have a greater appreciation of the possibilities of utilizing local health department personnel and facilities in their special area investigations. On the other hand, local health authorities should realize that applied epidemiologic research can be fitted into their routine programs. Each group expressed a feeling of satisfaction from this experience.

The immediate benefits which were gained during the operation of this Special Project were worthwhile, but of far greater importance are the potential long-range results which may develop. It is hoped that in the future, state and federal agencies will plan similar cooperative studies more or less following the pattern outlined in this report.

*The Interagency Committee is composed of: Fresno County Chapter of the American Red Cross, Agricultural Extension Service, County School Department, Fresno County Coordinating Council, Fresno General Hospital, Missionary agencies, Fresno County Tuberculosis Association, Central Valley Empire Association, and State Department of Employment.

At the local level, the health department has promulgated a program of continuous in-service training for the field staff, that they may better meet the needs of the agricultural workers. The community committees have been encouraged to help solve their own health problems. A number of the larger agricultural growers in Fresno County have been included in the work of these committees. Field conferences have been held with the growers and as their understanding of the problems increases, so in turn will the resources for the agricultural camps develop. Already, it has seemed necessary to provide health centers and classroom facilities in each of the larger camps. (Four of the ranch owners are now preparing such centers.) However, much more work is necessary at the local or community level, more contacts, continued interest, a better understanding for all groups involved, and an expanded educational program.

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Note: The statistical results of the Special Study are incomplete at this time, but will be reported in detail later.

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The authors wish to express their appreciation to the entire staff of the Fresno County Health Department and specifically to the following persons for their assistance, advice, and untiring efforts in carrying out this project: Miss Winifred Erskine, Director of Public Health Nurses; Mr. Wilfrid C. Kennell, Director of Laboratories; Mr. Joseph Reich, Director of Sanitation.

Crushed Ice Packing in the Treatment of Burns

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APPLICATION of packs of crushed ice to damaged areas in the treatment of severely burned patients has many advantages medically, and in addition it is a method adaptable to administration by trained lay personnel if that should become necessary in the event of atomic attack or other such catastrophe.

The treatment was used as an emergency measure aboard a Navy vessel in wartime after supplies needed for conventional methods had been exhausted. Fifty patients were extensively burned in gasoline and other explosions during enemy attack. With materials on hand at the outset, standard methods were employed to overcome shock, relieve pain and prevent dehydration. Each patient was given frequent 0.03 gm. doses of morphine sulfate, oxygen by nasal catheter, and infusion of at least a pint of plasma per day. Normal saline solution and saline solution with 5 per cent glucose were given intravenously as indicated. The burned areas were wrapped in pressure bandages of vaseline gauze.

For the first two or three days after injury the patients appeared to do well, but in many cases pulmonary edema developed on the fourth day. In such instances the extremities swelled and hacking cough and irrationality developed. Some of the patients died and others were in critical condition.

In all cases of major burns, the vein in which plasma was given soon collapsed. It was necessary to cut down the vein for subsequent infusions, and in the course of the procedure the formation of large thrombi was noted. When a vein that had not been used for infusion for several days was cut down, many thrombi were found to be breaking loose. It was assumed that these thrombi were lodging in the alveoli of the lungs and causing pulmonary edema.

At the time of these observations, supplies of plasma were exhausted and infusions then were confined to saline or saline and glucose solutions. The condition of the patients improved.

Subsequently in the treatment of patients with severe burns, crushed ice was applied to the damaged areas. Shock and pain were immediately relieved and the patients had a sense of well-being. Glucose and water was given intravenously. Usually the chilling packs were kept in place for two or three days—the length of time depending upon the condition of the patient—to give opportunity for restoration of normal circulation. Use of crushed ice was cumbersome and improvisation was necessary in fitting it to the needs in each case, but there appeared to be other benefits beyond overcoming shock and relieving pain. Pulmonary edema was of lesser incidence. Loss of plasma was diminished, although not eliminated. It is probable that the absorption of dead blood cells and tissue cells was retarded and toxemia thereby reduced. Other probably tenable suppositions are that cold lowered the metabolic demands of the lesions, decreased the amount of necrosis, and tended to retard bacterial growth and secondary infection.

Aside from these factors, which in sum may be life-saving in cases of severe and extensive burns, cold may be considered as an effective method merely for relieving the pain of less serious burns. In the author's experience, the relief given by packing in crushed ice was superior to that obtained with morphine sulfate.

In any event, crushed ice packing is a method to be considered in these times when an atomic bomb attack could cause serious burns in so large a proportion of the population of an area that available physicians, using standard methods, could not cope with the problem. In such circumstances, early application of crushed ice by trained lay personnel might save lives.

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Proper Use of Antibiotics in Treatment of Acute Otitis Media

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SUMMARY

The problem of preventing loss of hearing following acute otitis media has been made more complex by the use of penicillin and other antibiotic agents which may apparently cure yet leave dangerous residual disease. The causes of loss of hearing must be recognized early if remedial treatment is to be effective. In children particularly, loss of hearing may go unnoticed for some time.

Physicians who treat otitis media should feel the responsibility not only of bringing an acutely ill child back to health but of preserving the function of the hearing mechanism. Careful examination of the ear after apparent subsidence of infection is mandatory. It is of the utmost importance to be able to recognize the ear drum in its normal state and its various pathological states and to be alert to the early signs of changes associated with loss of hearing. Antibiotics should not be expected to do more than help combat the acute infection in otitis media. Adequate follow-up demands strong suspicion of residual pathologic process in the ear. The prevention of loss of hearing still requires knowledge of the established clinical facts and therapeutic procedures and the application of this knowledge to treatment of acute infections of the middle ear.

N the past few years great strides have been made in the development and use of chemotherapeutic and antibiotic agents. In many respects these drugs have changed concepts of treatment of disease by otologists as well as by physicians in other fields. Enough time has elapsed to evaluate the results of at least one of the earliest of these drugs—penicillin.

Many physicians regard sulfa compounds and penicillin, especially the latter, as truly "miracle" drugs. They have discarded the time-consuming procedure of adequate history-taking and thorough physical examination of the patient in favor of indiscriminate administration of large amounts of penicillin. Such promiscuous use of the drug tends to mask the true, basic clinical facts and may camouflage irreversible or progressive disease states. "Shotgun" therapy with these new drugs cannot properly be substituted for sound diagnosis.

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That penicillin is a powerful therapeutic agent is undeniable, but proper use of it requires that certain principles of therapy be followed. The drug is bacteriostatic at low concentrations and is bactericidal in high concentrations against a large variety of organisms. It is necessary to produce an optimal concentration of the drug at the site of infection and to maintain the concentration until the organisms have been eradicated. The desired result can be obtained only if dosage is sufficiently large and continued until complete recovery of the patient. Although now there is less tendency to underdose, many physicians still are prone to cease administration of the drug too soon. Even when these principles are observed, antimicrobial drugs cannot be substituted for drainage of a suppurative focus, because in such cases they are least effective due to their inability to penetrate the pus-filled cavity.

In the treatment of acute otitis media, penicillin and other antimicrobial agents unquestionably are of great value, but principally as adjuncts to established therapeutic procedures. In this disease indiscriminate use of such drugs often masks clinical manifestations and allows pathological processes to become irreversible. The course of treatment still should be guided by proper diagnosis based on careful history-taking and thorough examination of the patient—including the ears. In a small child, ill and frightened, this examination may be time-consuming and even unpleasant. Nevertheless, the ears should be gently and thoroughly cleansed of cerumen and debris so that the condition of the tympanic membrane may be observed. This may be elementary and obvious, but experience in the past year or so has shown that some physicians believe it no longer is necessary to see the ear drums "because a shot or two of penicillin will cure the ears anyway."

It is true that penicillin may reduce the fever and stop the pain but it will not necessarily bring the ear back to a normal state. In fact in many such cases the ears do not return to normal. Upon examination of the tympanic membrane following "cures" with penicillin, it may be observed to be dull, thickened and retracted. There may be retraction of Shrapnel's membrane which later could lead to cholesteatoma. There may be a change to chronic suppuration. There may be adhesions separating the attic from the lower tympanum, permitting the infectious process insidiously to continue for several months in the attic or mastoid space without previous clinical manifestations until epidural or perisinal abscess finally manifests itself. These are not theoretical possibilities—they are actually occurring. All otologists who work with children have observed such cases. Examples of each of the latter

two complications were observed recently. In one case epidural abscess occurred three months after an acute infection of the ear apparently had been successfully treated with penicillin; in the other, perisinus abscess developed four months after infection of the ear subsided with penicillin treatment. However, these are the relatively infrequent end results of insufficient treatment and observation. The commonest result is loss of hearing, which frequently is overlooked in children both by physicians and parents. Maintenance of the function of the ear —that of hearing—must not be forgotten in the treatment of ear infections.

In suppurative otitis media, incision of the tympanic membrane at the proper time is the best insurance against chronic suppuration or chronic adhesive processes leading to loss of hearing. The drainage of pus under pressure still is a surgical first principle. Neglect of this principle by the physician whose indiscriminate use of antibiotics has lulled him into a sense of safety may lead to adhesions in the middle ear, permanent retraction of the tympanic membrane or chronic perforations with subsequent loss of hearing.

The majority of middle ear infections which respond magically to one or two injections of penicillin are those which in years past responded to glycerin drops, heat and decongestants. Secretory or non-purulent otitis, observed frequently as a complication of the common cold, of viral infections of the respiratory tract, of hypertrophied adenoid tissue and of allergic rhinitis, may cause symptoms of pain and low-grade fever in children. Otitis media of this type is caused by obstruction of the eustachian tube, and responds to decongestants which restore aeration of the middle ear and permit drainage of the secretion. Much of the evidence of the effectiveness of penicillin in the treatment of otitis media is based on the false premise that otalgia means suppurative otitis media. As a matter of fact, the otalgia may be due to a reddened, retracted tympanic membrane and a vacuum in the middle ear or to an accumulation of non-suppurative transudate or exudate. It is well established that acute non-suppurative otitis media and most suppurative infections of the middle ear with bulging of the drum respond to myringotomy and treatment directed toward the underlying causes. After myringotomy the temperature drops, the otalgia soon ceases and in a few hours the child usually is comfortable and asleep. If penicillin is administered at the same time, the credit for this rapid improvement is given to the drug, whereas in practically all cases it is the result of releasing the pressure of fluid or pus in the middle ear.

Antibiotics are most valuable when used as adjuncts in those cases of otitis media in which the organism is virulent, the patient is febrile and the response to drainage, local cleansing and general measures is not satisfactory. In such cases the antibiotics used should be given in adequate doses and continued until the ear has returned to normal. This cannot be determined without adequate inspection of the ear drum during the period of convalescence. This, of course, requires that the physician know how to cleanse the canal and drum without trauma and be able by observation to determine the condition of the drum and middle ear at all stages of the disease. Frequent observation of the tympanic membrane is even more important when penicillin or other antibiotics are being administered than when simple myringotomy has been done without use of these drugs. If antibiotics are used, there are no warning symptoms of pain and fever which alert the physician to possible complications arising during the course of the disease. Critical observation of the ear is the only way of determining the more chronic and less dramatic changes which may result from acute otitis media and lead to loss of hearing which often is not discovered in children until several such attacks have occurred and irreversible changes are present in the drum or middle ear.

Rupture of the tympanic membrane may occur even when the patient is being given adequate antibiotic therapy. It is not uncommon for children who are being treated for pneumonia or other systemic disease to start having aural discharge, often without fever or much pain. This could be anticipated by daily observation of the ears at the same time as the general examination—but only if the examining physician is able to determine what process is going on in the middle ear. Such knowledge can be acquired only by repeated observation of ear drums, both normal and abnormal. Spontaneous rupture of the ear drum should be avoided if possible. Although this may seem obvious, there is a growing trend among pediatricians and general practitioners to say, "What does it matter if the drum ruptures?" It does matter, for although in some cases, fortunately, the rupture occurs early and at the optimal site—the postero-inferior quadrant where scarring will cause minimal loss of hearing — in others it may occur in Shrapnel's area, leading to chronic attic suppuration and later cholesteatoma, or marginally so that healing does not occur, or anteriorly where it may remain a chronic perforation through which mucous secretions from the eustachian tube are discharged. In any case rupture is caused by ischemic necrosis, a gradual tearing process with pus tunneling through the layers of tympanic membrane, which leads to greater scarring of the drum than a clean incision as in myringotomy. Before and during the occurrence of rupture, the pressure of pus in the middle ear is transmitted by way of the aditus to the mastoid air cells, causing inflammation and edema of the lining membrane. In most cases in which spontaneous rupture has occurred, drainage is inadequate so that, regardless of the site of rupture, incision of the tympanic membrane in the postero-inferior quadrant is desirable. A gush of pus following myringotomy will prove this point; and usually prompt subsidence of symptoms occurs.

Often if antibiotic therapy is discontinued too soon the drug acts merely as a bacteriostatic agent and symptoms may recur in five to 14 days. Such recurrences are frequently erroneously taken to be

new infections. Cases have been observed in which children have had recurring earaches every ten days or two weeks over a period of months, each time apparently being "cured" by a "shot" or two of penicillin. Such a prolonged state of infection obviously is damaging to the delicate hearing mechanism.

After all infection has subsided, the tympanic membrane should be observed to be pale, thin and in normal position. Hearing should have returned to normal. If there is any doubt of this after a few simple hearing tests have been made, an audiogram should be obtained. If hearing is below normal, attention should be directed toward possible causes. The commonest cause of conductive hearing loss in children, as well as the most frequent cause of repeated attacks of otitis media, is obstructive adenoid tissue. This is often complicated by allergic disease and sinus infection. Complete removal of the adenoid tissue, with special attention to obstructive tissue high in the vault and in the fossae of Rosenmuller, often will clear up repeated otitis media and return hearing to normal. In some instances, further procedures may be necessary — allergic sensitivity studies, irradiation of the nasopharynx, inflation of the eustachian tubes, or treatment of sinusitis. None of these measures will be of great value in restoring hearing if the condition has been neglected for so long that irreversible changes, such as chronic adhesive processes in the middle ear, thickening and retraction of the tympanic membrane or chronic suppuration, have occurred.

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Discussion by VICTOR GOODHILL, M.D., *Los Angeles*

I have long waited for someone to say so eloquently what Dr. Rutherford has stated in her important and excellent paper.

It is interesting to review the chronologic story of the treatment of acute otitis media from about 1936 to the present. During these 15 years a veritable therapeutic drama has occurred in the treatment of the patient with acute otitis media. Prior to the advent of the first chemotherapeutic drug, prontosil, prompt myringotomy and supportive therapy was a fairly adequate treatment. In spite of this, however, mastoiditis and its sequelae were not infrequent complications. The utilization of prontosil, followed later by sulfanilamide and other sulfonamides, decreased the incidence of complications. The further advent of penicillin decreased still further the dreaded complications of otitis media.

This change in therapy, however, created a rather startling attitude toward tried and true surgical principles. The necessity for the drainage of pus lost its importance to some physicians, and reliance upon sulfonamides and antibiotics alone became more and more widespread. This reliance was largely strengthened by the fact that many children showed such apparent quick response to non-surgical therapy. In effect, many pediatricians stated that myringotomy was now a useless and an unnecessary procedure and that otitis media could be completely controlled by medical means entirely, provided the drugs were used early and in proper dosage. Undoubtedly there was some truth to these statements, but experience has shown that the defiance of surgical principles is quite unsafe. As time goes on there is growing evidence of incomplete bacteriostasis and bactericidal activity of the antibiotics in otitis media. Complications are now occurring with greater frequency due to increased virulence of new generations of organisms and also to disregard of surgical principles in the conduct of temporal bone infections. As Dr. Rutherford has so ably emphasized, intracranial complications can and do occur in spite of antibiotics; recognition of them is infinitely more difficult, and treatment frequently too late, because of masking phenomena. The functional impedance of hearing produced by conduction deafness is becoming more common. Serous effusion of the tympanum occurs more frequently than ever before, probably because of incomplete resolution of the suppurative process, due to the effect of the antibiotic drugs.

One wonders whether there is therapeutic wisdom in withholding from the patient the innocuous and logical release of pus by myringotomy as compared to the administration of half a dozen injections of penicillin, plus innumerable expensive oral antibiotics, many of which produce gastrointestinal disturbances of major degree and allergic reactions that may be quite disabling. Is it not time for a sober reevaluation of therapeutic principles and surgical concepts in acute otitis media?

Giant Intracanalicular Fibroadenoma

With Report of Five Cases

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SUMMARY

Five cases of giant intracanalicular fibroadenoma ("cystosarcoma phylloides") were observed at one hospital in a period of three years. In a search of the literature, additional reports of breast tumors of this kind, not included in previous reviews, were noted. As there is record of 229 cases, it would appear that this rapidly growing benign tumor should be kept in mind in the diagnosis of masses in the breast.

If removal is incomplete, there may be recurrence. Simple mastectomy is the treatment of choice. Radical mastectomy should be avoided.

JOHANNES MULLER is credited with classifying and assigning the name cystosarcoma phylloides to a non-malignant tumor of the breast which frequently grows rapidly to large size. Although the term assigned by Muller has been used for over a century, the description "giant intracanalicular fibroadenoma" is also used and would seem to be more accurate. The tumor has been reported by various other names, an excellent list of which was compiled by Owens and Adams. Recently the authors have observed five cases, which are reported in this presentation.

Giant intracanalicular fibroadenoma usually is observed as a freely movable mass replacing most of the normal breast tissue, with no retraction of the nipple and no axillary lymph node enlargement. Changes in the skin over the mass are rare. They occur only when local necrosis and ulceration are caused by the large size of the growth. The tumor is characterized by rapid and bulky enlargement, sometimes after a long period of little or no growth. Histologically it has many of the features of sarcoma, but it does not metastasize. Although infrequent cases have apparently been of a malignant variant,[6, 34] the neoplasm is considered to be benign. It is generally accepted that simple mastectomy is the treatment of choice.

LITERATURE

Lee and Pack,[20, 21] reviewing the literature in 1931, collected reports of 105 cases and reported six cases they had observed. Owens and Adams[29] collected reports of 12 cases published between 1931 and 1941 and themselves reported a case. A number of cases have been reported since 1941. In addition, in a search of the literature, reports of a number of cases not included in previous reviews were noted: Six cases reported by Greenough and Simon[15] in 1911, four by Geist and Wilensky[13] in 1915, one by Martin[26] in 1933, two by Smith in 1935, one by Crile[8] in 1938, and one by Hopkins[18] in 1940.

White[34] reported a case in which a 34-year-old woman died with metastases from a sarcomatous breast tumor which he concluded was a malignant variant of giant intracanalicular fibroadenoma. Hill and Stout[16] reviewed in detail ten cases observed at Columbia University School of Medicine between 1911 and 1940. They used the term "adenofibrosarcoma, intracanalicular type." Althabe and Beruti[3] reported a case in which a 45-year-old woman had a 1,800-gm. tumor of the left breast. Hinterberger[17] reported a case of giant intracanalicular fibroadenoma in a 39-year-old woman. In 1943 Cooper and Ackerman[6] reviewed the history of three patients with the disease. One of these had several recurrences and axillary metastases. In that case the growth was considered malignant.

Fox and co-workers[11] treated a 15-year-old unmarried girl with a breast tumor "the size of a baby's head." They also reported the case of a married woman, 50 years of age, with giant intracanalicular fibroadenoma "the size of a large orange." Marano[25] reported upon a 28-year-old woman with "myxoma of the breast." (It is assumed the lesion was giant intracanalicular fibroadenoma.)

Adair and Herrmann,[1] in a discussion of sarcoma of the breast, mentioned 45 cases of giant intracanalicular tumor observed between 1926 and 1944 at Memorial Hospital, New York. Assuming that this included the six cases originally reported by Lee and Pack,[21] then this represents 39 additional cases to be added to the total.

Aiken[2] reported a case of a 68-year-old woman with a tumor weighing 2,370 gm. He used the term "Brodie's disease of the breast." (Giant intracanalicular fibroadenoma was described in the English literature by Sir Benjamin Brodie[4] in 1840, and his name is occasionally still used in connection with it.)

Montenegro and Marcondes[27] reported a case of giant intracanalicular fibroadenoma in the South American literature. Jones[19] mentioned seven cases observed by him. Llewellyn[22] reviewed the case of a

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78-year-old woman with a "giant adenosarcoma" weighing 4,650 gm. — undoubtedly a giant intracanalicular fibroadenoma. Clarke[5] treated a 52-year-old woman with a 10-pound tumor of the breast. The patient also had a toxic adenoma of the thyroid gland. Walsh and Warren[33] reported a case in which a 47-year-old woman had a giant intracanalicular fibroadenoma 14 cm. in diameter. Gerwig[12] reported removal of a 7,830-gm. tumor from the breast of a Negro woman. Mannix and Wildnauer[24] presented a case in which a 29-year-old woman had a tumor of the left breast that weighed 4,785 gm. Ulceration through the skin occurred. In the right breast were three nodules which also proved to be giant intracanalicular fibroadenoma. McDonald and Harrington[23] summarized 13 cases observed at the Mayo Clinic between 1904 and 1943.

In all, 224 cases of breast neoplasm of this type have been reported to date. The authors have observed five additional cases.

CASE REPORTS

CASE 1: A 33-year-old Negro woman was admitted to hospital March 2, 1949, with productive cough and enlargement of the left breast. The patient said that fever and productive cough had been present for four months and that in that time body weight had decreased 20 pounds. A small lump in the left breast had been noted about one year previously. It remained unchanged for about six months, then began to grow rapidly. The patient had had seven pregnancies, four terminated by abortion and two by stillbirth; there was one living child, 17 months of age, which the patient had nursed.

The left breast was firm and enlarged to 12x15x15 cm. In an x-ray film of the chest a pulmonary cavity involving almost all the left upper hemithorax was observed, and there was also some infiltration of the right central lung field. The sputum contained many acid-fast bacilli. A diagnosis of pulmonary tuberculosis was made. Pneumoperitoneum was carried out and streptomycin was administered. The question of tuberculous involvement of the left breast was considered in the differential diagnosis of the tumor.

On March 15, 1949, simple mastectomy was done with local anesthesia. A part of the pathological report follows:

The specimen consisted of an ovoid mass of firm, rubbery, nodular tissue, measuring 14x11x6 cm. (Figure 2). On the cut surface numerous translucent nodules of pale yellowish tissue, measuring from 2 to 5 cm. in diameter, separated by very thin fibrous septa, were observed. There was an occasional small cystic cleft containing clear, pale green, gelatinous material. In histological sections the basic pattern of intracanalicular adenofibroma was observed (Figure 3). There had been no recurrence of the growth at the time of this report.

CASE 2: A 32-year-old unmarried nulliparous Negro woman was admitted to hospital because of an irregular, enlarged uterus and a mass in the left breast. A small lump had been present in the left breast for three years, but more rapid enlargement of the mass had been noted during the preceding six months.

Two of the patient's sisters had had uterine "fibroids" removed, each at the patient's present age. The patient had had rheumatic fever at the age of 10 and had had occasional exacerbations since.

Upon physical examination a systolic mitral murmur was noted. There was a firm, movable 8x6x5 cm. mass occupying the upper inner quadrant of the left breast. In the lower abdomen was an irregular movable mass the size of a fetus at six months. The following diagnoses were made: (1) rheumatic heart disease, (2) probable fibroadenoma of the left breast, (3) leiomyomata of the uterus.

On April 8, 1949, the mass in the left breast was removed. In a frozen section it was observed to be giant intracanalicular fibroadenoma (Figures 4 and 5).

A large leiomyomatous uterus was removed in total hysterectomy a week later. Recovery from both operations was uneventful.

CASE 3: A 51-year-old married white woman was admitted to hospital August 11, 1949. She said she had had a "benign

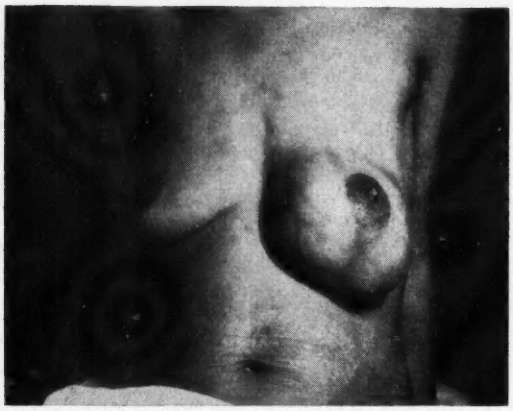

Figure 1 (Case 1).—Bulky tumor of the left breast with no evidence of nipple retraction or of "orange peel" skin.

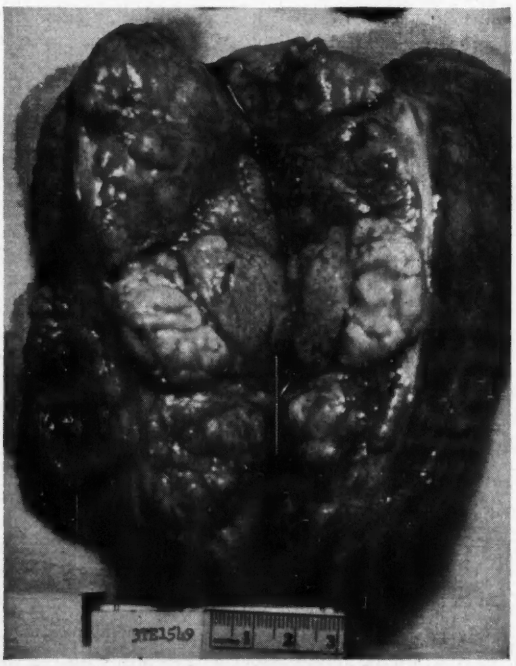

Figure 2.—Cut surface of tumor in Case 1. Note the lobular structure in which, grossly, there is no evidence of invasive growth.

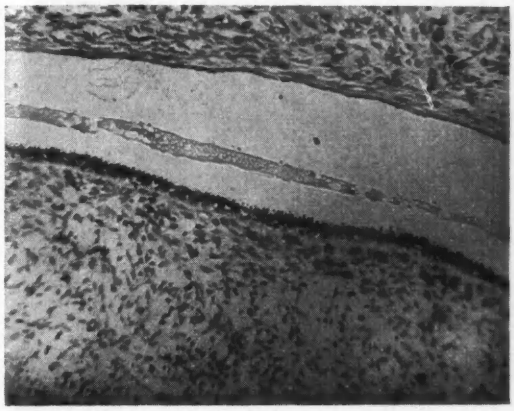

Figure 3 (Case 1).—At the lower portion of the picture is the edge of an intracanalicular mass. The myxomatous character is easily seen.

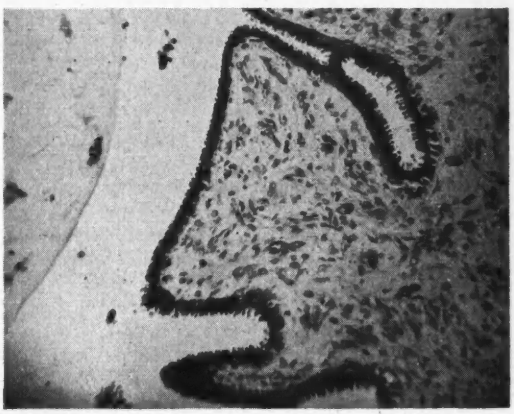

Figure 4 (Case 2).—The serrated margin of the papillomatous growth in a large cystic duct. The resemblance to the edge of a leaf has given the tumor one of its names—phylloides, meaning "leaf-like."

lump removed from the left breast" in 1945. About a year later the patient noted recurrence of a small mass which continued to enlarge during the ensuing three years. She had been married for 32 years and had two daughters, ages 31 and 15, living and in good health.

There was a 10x7 cm. mass in the left breast. Axillary lymph nodes were not palpable.

A preoperative impression of giant intracanalicular fibroadenoma was recorded by a member of the staff, and simple mastectomy was carried out when a biopsy specimen examined in frozen section confirmed the diagnosis. The gross specimen and paraffin sections were typical of giant intracanalicular fibroadenoma.

Case 4: A 56-year-old Portuguese widow was admitted on March 31, 1946, with history of progressive enlargement of a mass in the left breast over a period of two years.

The mass, the size of a small orange, was firm and freely movable. No axillary lymph nodes were palpable.

On April 4 a biopsy specimen was removed. Examination of a frozen section strongly indicated the tumor was malignant, and left radical mastectomy was done. In later examination of a paraffin section, the structure was observed to be typical of giant intracanalicular fibroadenoma, for which simple mastectomy would have sufficed. There has been no evidence of recurrence, but the patient has had some swelling of the left arm since the operation.

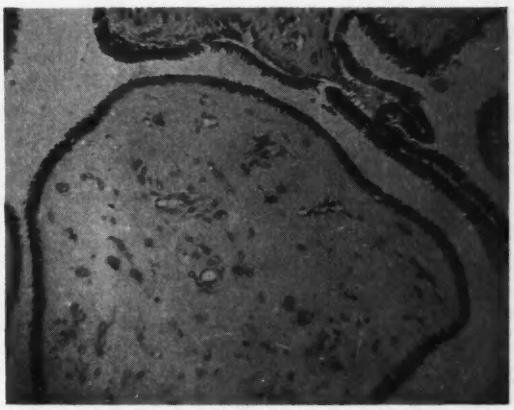

Figure 5 (Case 2).—Papillomatous growths into a cystic duct. Large bizarre nuclei are visible in the fibrous stroma.

Case 5: A 47-year-old single white woman was admitted to the hospital December 10, 1949. A benign tumor diagnosed as adenofibroma had been removed from the left breast at another hospital in 1940.

Five weeks before the present entry the patient had noted in the left breast a small mass which rapidly increased in size during the two weeks immediately prior to entry.

Upon physical examination the left breast was observed to be replaced by a firm, rounded mass, approximately 10 cm. in diameter, which was not fixed either to the skin or to the wall of the chest. Axillary lymph nodes were not palpable.

A preoperative diagnosis of giant intracanalicular fibroadenoma was made. After the diagnosis was confirmed in examination of a frozen section, simple mastectomy was done. The wound healed rapidly and there has been no evidence of recurrence.

CONCLUSION

As 229 cases of giant intracanalicular fibroadenoma, including five cases in this presentation, have been reported in the literature, it would appear that breast tumors of this type are more common than was previously assumed. In diagnosis of masses in the breast this rapidly growing benign tumor should be kept in mind. Since incomplete removal may result in a recurrence, simple mastectomy would appear to be the treatment of choice. Radical mastectomy should not be done.

Cass Street at Carmelita Avenue.

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CASE REPORTS

Teratoma of the Ovary in a Sixteen-Month-Old Child

A. GILMAN, M.D., J. SMITH, M.D., I. PUZISS, M.D., and L. KARP, M.D., *San Francisco*

A CASE of teratoma of the ovary in the youngest patient of record to have such a lesion was reported by Garrett[2] in 1950. The patient was 20 months of age and the presence of the tumor was noted in a routine examination. Up to that time the youngest patient in a reported case of teratoma of the ovary was three years of age. The case was reported by Harris[3] in 1917. The youngest patient with this lesion reported by Ladd and Gross[4] was six years of age. In the British literature[1] there are reports of cases at the age of four and six years. Also reported was twisted ovarian cyst in a two-year-old child, but without final pathological diagnosis.

Tumors of the ovaries in children can occur at any age, but are most common between the ages of 10 and 15 years. In the case here reported the patient was 16 months of age.

CASE REPORT

A 16-month-old white female was admitted to the pediatric service of Mount Zion Hospital August 7, 1949, because of abdominal pain of 24 hours' duration. From the history obtained from the mother it appeared that the child had been well until the afternoon of the day before entry, when she was noted to be drowsy and lethargic. About 9 p.m. the child cried and vomited. Upon examination by a physician a tender mass filling the right side of the abdomen was palpated. The child did not appear acutely ill. An enema was given. The fluid subsequently discharged contained no feces and there was no evidence of blood.

The next morning the child appeared to feel well. She ate and retained her usual breakfast. By early afternoon she was fretful and had a temperature (rectal) of 103° F. She was then admitted to the hospital.

When examined upon admission the patient did not appear to be acutely ill. The rectal temperature was 103.6° F. The pulse rate was 90 per minute. A firm, tender mass, dull to percussion, filled the entire right side of the abdomen and extended up into the epigastrium. No abnormality was noted in a rectal examination.

In x-ray films of the abdomen a mass in the right side, displacing the bowel to the left, was observed, and there was moderate distention of the small bowel. In barium enema studies the cecum was not visualized, but there was a small amount of gas in the cecum and ascending colon, which were displaced to the left by the mass. The films were suggestive of intra-abdominal fluid on the right side, and an irregular density resembling calcification was present in the upper part of the mass.

Leukocytes in the blood numbered 14,600 per cu. mm.—64 per cent polymorphonuclear cells, 2 per cent monocytes, and 34 per cent lymphocytes; 18 per cent of the total were non-filamented forms. The hemoglobin content of the blood was 12 gm. per 100 cc. The urine was normal except for a trace of acetone.

Exploratory laparotomy was carried out through a long right rectus incision. A 9.5x8x8 cm. red-purple cystic tumor with several hard nodular areas filled the right side of the abdomen, and the bowel was pushed to the left. The tumor grew from the right ovary, and the pedicle and the fallopian tube were twisted 180° counterclockwise, strangulating the tumor and the tube. The tube appeared gangrenous. After the pedicle and tube had been untwisted, it was felt necessary to remove the tube and the mass together.

The postoperative course was uneventful and the patient was discharged from the hospital on the ninth postoperative day.

PATHOLOGICAL REPORT

Macroscopic examination: The specimen was a lobulated bosselated spheroidal mass 9.5x8x8 cm. The surface was smooth, purplish-grey and slightly dulled. A tube approximately 6 cm. long was stretched out along a pedicle that was 4 cm. long. Sections were extremely cellular with alternating zones of hemorrhage and necrosis. The cellular parts were soft, and varied in color from pink to gray. There were some zones of calcification scattered somewhat irregularly throughout but generally in the capsule. Most of the cystic areas were 2 to 3 cm. in diameter. No invasion of the capsule was observed.

Microscopic examination (See Figure 1): In sections of the capsule of the tumor laminated layers of fibrous tissue separated by a considerable amount of blood were observed. In a section through the pedicle and tube there was a loose fibrous stroma in which there was much blood. This extensive hemorrhage involved the tube, which was otherwise normal. The tumor was adherent to the cyst wall, and at no place in the sections was there evidence of invasion through the wall. In the tumor there was a wide variety of cells, all of them quite adult in configuration and structure. The most common tissue in this teratomatous tumor was brain tissue, represented by a loose formation of glial tissues with large dilated and congested blood vessels and a diffuse scattering of leukocytes and lymphocytes. In some places the tissue was necrotic. Associated with the brain tissue and scattered irregularly throughout were many structures that resembled respiratory tract, particularly trachea. The arrangement of epithelium, smooth muscle, and cartilage was quite striking. There were large cystic zones lined by stratified squamous epithelium, and beneath the epithelium there were epidermal structures including hair follicles and glands. In a few places the respiratory epithelium of the pseudo-tracheal structures

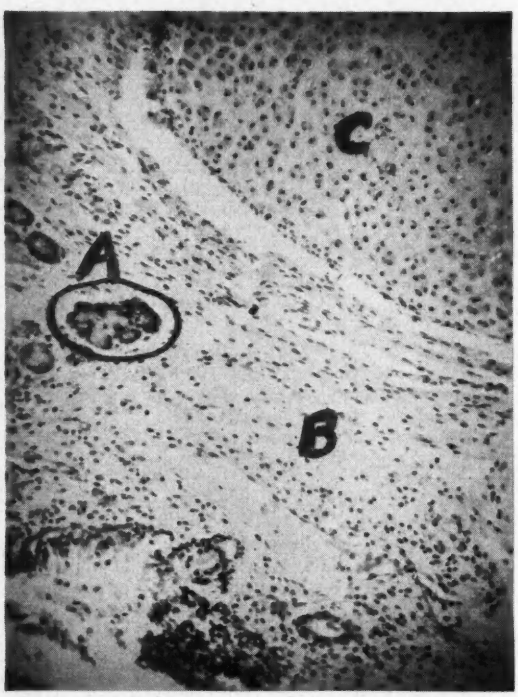

Figure 1.—Section of specimen. *A*—Primitive respiratory epithelium. *B*—Nerve tissue, glial in nature. *C*—Cartilage.

was necrotic and inflamed. In a few regions beneath the stratified squamous epithelium there were zones of fat adjacent to the glial substance. Some poorly formed pulmonary tissue was present. There was no evidence of neoplastic alteration of any of these tissues.

Pathologic diagnosis: Ovarian teratoma composed of adult tissues and showing early acute hemorrhagic necrosis.

DISCUSSION

In this case, rather typical of twisted ovarian cyst, a preoperative diagnosis of dermoid or teratomatous cyst was made with the aid of x-ray studies. Before the x-ray examination was carried out, a diagnosis of intussusception was considered. Had the fairly common occurrence of twisting of the mass on its pedicle not occurred, the presence of the tumor might have gone unrecognized for many months.

SUMMARY

A case of teratoma of the ovary in a 16-month-old child is reported. The patient is believed to be the youngest of record to have the lesion.

Mount Zion Hospital.

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Osteochondritis Dissecans of the Supratrochlear Septum

CHARLES A. ROWE, M.D., *Oakland*

IN the five years since Morton and Crysler[4] first described osteochondritis dissecans of the supratrochlear septum and reported six cases, several additional cases have been reported.[1, 2, 3, 5]

A review of the reports indicates that the lesion usually occurs in young persons, more often in the knee than in other joints, and that more males than females are affected. It is generally agreed that the lesion starts with trauma which is followed by a necrotic process in which a bony fragment separates beneath articular cartilage.[2, 3, 4] With regard specifically to such lesions in the olecranon fossa, it is believed by some investigators[1, 4] that the fragment arises from within the supratrochlear septum. Ross,[3] on the other hand, expressed the opinion that the process originates in some other part of the elbow joint and that the fragment, migrating, becomes wedged in the olecranon fossa. Observations in the case here reported seem to support Ross's opinion.

REPORT OF A CASE

A 19-year-old United States Marine injured the right elbow slightly while in Okinawa in January 1947. No specific medical treatment was given. During the next several months, there was dull aching in the right elbow joint, with restriction of flexion and extension.

Upon physical examination when the patient was first observed in August 1947 at the U. S. Naval Hospital, Guam, the right elbow lacked 20 degrees of full extension and 10 degrees of complete flexion. The patient complained of dull aching within the olecranon fossa. In roentgen studies a sclerotic ovoid free fragment of bone occupying the supratrochlear septum of the right humerus was observed. The fragment, measured in projected dimension, was 10 by 15 mm. in the anterior-posterior film and 15 by 15 mm. in the lateral film. It was apparent that there was interference with full flexion and extension.

On Sept. 8, 1947, arthrotomy of the right elbow joint was carried out. A longitudinal incision three inches in length was made across the posterior lateral aspect of the elbow. The triceps tendon was reflected medially, the elbow joint was entered and the olecranon fossa exposed. A free osteochondritic body 1.5 cm. in diameter was removed. In careful examination of the articular contour of the olecranon fossa, nothing which would indicate the origin of the osteochondritic body was observed. The operative site was irrigated with sterile water and the wound was closed in layers with cotton sutures.

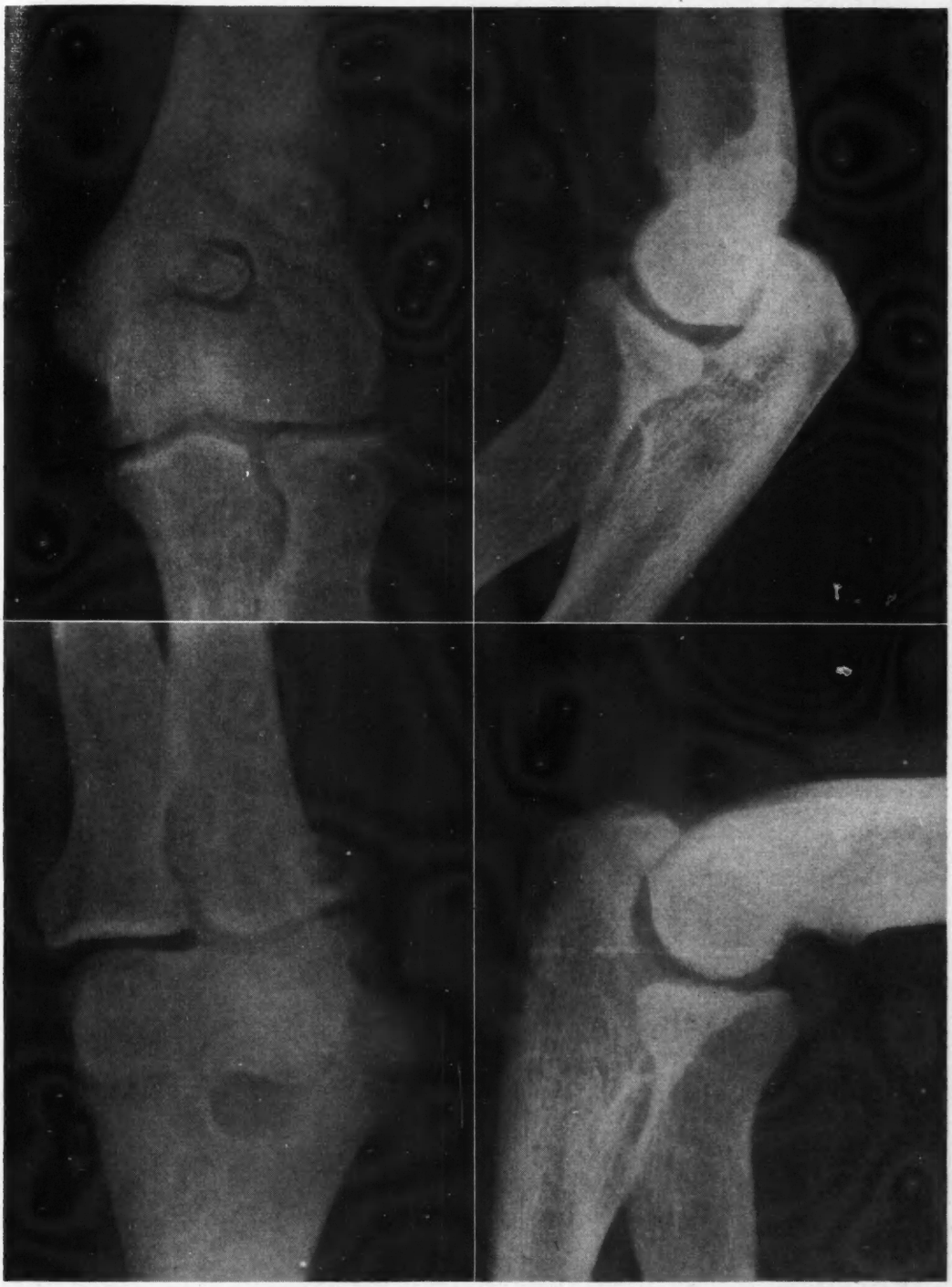

Figure 1.—*Upper left*—Osteochondritic body observed in anterior-posterior film. *Upper right*—Osteochondritic body in lateral view. *Lower*—Corresponding films after operation.

The postoperative course was uneventful and the patient was discharged to full duty on Sept. 26, 1947. In roentgenograms taken a month later the joint appeared to be normal. When last observed several months later the patient had a full range of motion of the right elbow without discomfort.

SUMMARY

A case of osteochondritis dissecans of the olecranon fossa is reported.

Observations at operation indicated that the process occurred elsewhere in the elbow and by migration lodged and hypertrophied within the fossa.

Surgical intervention with removal of the loose body offers the best results for this condition.

3400 Webster Street.

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EDITORIAL

Officially Yours

This issue of CALIFORNIA MEDICINE carries the transcript of the annual meeting of the House of Delegates of the California Medical Association. These proceedings are printed in full, rather than in condensed version, so that every member of the Association may read for himself just what proposals were made and what actions taken by the official policy-making body of the C.M.A.

Several sections of this transcript are of more than ordinary interest to all physicians and study of them is recommended. Among these are the statement of Dr. John W. Cline, a Californian who is now serving as president of the American Medical Association. Dr. Cline condensed into a few minutes the entire philosophy of the American Medical Association as a body devoted to public service. At the same time, he pointed to the role of every physician in representing the medical profession to the public and especially to those bodies and organizations which stand shoulder to shoulder with medicine in fighting for the preservation of the American system of competitive enterprise.

Another address of unusual interest is that of Dr. Dwight H. Murray, legislative chairman of the C.M.A. and of the A.M.A. and now serving as chairman of the A.M.A. Board of Trustees. Dr. Murray, with the able assistance of Mr. Ben H. Read, executive secretary of the Public Health League of California, gave a full account of the legislative activities of the 1951 California State Legislature. Every physician should read this story as a means of orienting himself in the legislative process and the need for legislative representation for medicine.

In a different vein but equally interesting is the address to the House of Delegates by William T. Bender, son of a physician and a senior medical student at University of California. Mr. Bender, who has been active in organizing a student chapter of the American Medical Association at his school, discussed the attitudes and philosophies of his fellow students and detailed the aims which some of their leaders have in developing active chapters of the Student A.M.A. in the medical schools of the state. His comments were startling and refreshing, and they are decidedly worth reading and heeding.

In addition to these formal presentations, the House of Delegates proceedings carry the discussion on the new Constitution and By-Laws, which will be printed in full in next month's issue. Every member should be familiar with these basic documents which govern his organization. Similarly, every member should familiarize himself with the annual budget as adopted by the House of Delegates. This shows where his money goes and for what purpose.

The California Medical Association is your own organization. Its annual sessions provide the opportunity for the transaction of business and the adoption of official policies. Each year at this time there is a chance for every member to review the official actions of this duly elected official body and to determine whether or not these actions, taken in the democratic process, represent the thinking of himself and his colleagues. If so, the member has been truly represented in policy-making; if not, the member may want to consider a different representation in future meetings. In any event, the entire report of the House of Delegates is here for perusal. May it shed light on the activities of the Association for those not fortunate enough to attend the annual session.

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C.M.A. House of Delegates Proceedings

SUNDAY AFTERNOON SESSION
MAY 13, 1951

The 48th Annual Session of the House of Delegates of the California Medical Association was held in the Biltmore Hotel, Los Angeles, California, May 13 to 16, 1951.

The Sunday afternoon session was held in the Music Room of the Biltmore Hotel, and was called to order at 1:30 p.m. by Speaker Lewis A. Alesen, who presided.

SPEAKER ALESEN: The House of Delegates will please come to order.

Dr. Morrison of Ventura, chairman of the Credentials Committee, is recognized.

Dr. Morrison, will you please step forward with your report?

REPORT OF COMMITTEE ON CREDENTIALS

DR. A. A. MORRISON: Mr. Chairman, we have 178 delegates seated, which constitutes a quorum.

I have here a written list of those delegates who have signed the Loyalty Oath.

SPEAKER ALESEN: Thank you.

It appearing that there is a quorum, I now declare this meeting of the House of Delegates of the California Medical Association duly constituted and open for business.

Mr. Secretary, will you proceed to call the roll.

. . . Roll call. . . .

SPEAKER ALESEN: The following committees have been appointed:

Committee on Credentials: A. A. Morrison, Ventura County, chairman; C. Meredith Guernsey, Butte County; Frederick Powers Heald, Imperial County.

Reference committee on the reports of officers, the Council and standing and special committees (Reference Committee No. 1): J. Lafe Ludwig, Los Angeles County, chairman; J. Needham Martin, San Bernardino County; James Graeser, Alameda-Contra Costa County.

Reference committee on finance, to review the reports of the Secretary-Treasurer and the Executive Secretary, and to study and make recommendations to the House of Delegates on the budget submitted by the Council and the amount of dues for the ensuing year (Reference Committee No. 2): Stanley Truman, Alameda-Contra Costa County, chairman; G. Wendell Olson, Orange County; Leslie B. Magoon, Santa Clara County.

Reference committee on resolutions, amendments to the Constitution and By-Laws, and new and miscellaneous business (Reference Committee No. 3): Lyle G. Craig, Los Angeles County, chairman; Henry Gibbons III, San Francisco County; H. Clifford Loos, Los Angeles County.

A word of explanation is in order about Reference Committee No. 3.

Our good friend, Dr. Wesley Smith, was selected to be chairman of this Reference Committee No. 3. Dr. Smith has had a serious operation and has been delayed a bit in his convalescence. He expected to come to this meeting even as late as Friday, when he called the Speaker to tell me he was ill and couldn't be here.

We want you to know Dr. Smith was a tireless worker on this committee last year, and we miss him very much. It was at his suggestion that Dr. Clifford Loos was selected to fill his place. As you know, Dr. Loos did some yeoman's work on this committee last year. I am sure the House of Delegates is very happy to have him.

Reference committee on executive session, to consider business brought before the House of Delegates in executive session (Reference Committee No. 4): J. P. Sampson, Los Angeles County, chairman; George Pimentel, Merced County; S. Condit Glasgow, Monterey County.

Does the House approve the appointment of these committees?

. . . There were no objections. . . .

SPEAKER ALESEN: Vice-Speaker Charnock announces that all the alternates and extra delegates have signed the delegate's card. We, therefore, are in business and ready to proceed.

At this time Dr. R. O. Bullis, president of the Los Angeles County Medical Association, would like to make an announcement. Dr. Bullis!

DR. R. O. BULLIS (Los Angeles County): Mr. Speaker, I would like to take this opportunity to announce to the House of Delegates that due to facts

uncontrolled by the American Medical Association it will be impossible to hold the interim meeting in Houston, Texas, and that Los Angeles, California, has been selected as the Interim Session meeting place in December. (Applause.)

SPEAKER ALESEN: At this time the next item of business before you is the vote on the proposed new Constitution for the California Medical Association.

The chair thinks it in order to give just a few words of history in order to explain why certain procedures have been adopted to facilitate and expedite the action on this document.

As you recall, in 1947 a special committee was appointed by order of this house to study the old Constitution and By-Laws and propose new documents if it saw fit. That committee was a 15-man committee under the chairmanship of Dr. Sam McClendon. That committee worked well and produced a document which it said was not complete at the 1948 session, and at the request of the committee it was discharged and a smaller committee of five, under the chairmanship of Dr. McClendon, again brought in the document at the 1949 session.

At that time the document was admitted and it lay on the table from 1949 to 1950.

In order to obtain the consensus of the House on the adoption, or for or against the proposed constitution at that time, Reference Committee No. 3 held a special pre-convention hearing in San Diego prior to the 1950 meeting. They sensed at that time that the opinion of the House was against the adoption of the document as it then lay on the table.

Therefore, they at that time brought in a new proposed document which attempted to reflect the consensus as it had been determined by the committee's hearings on the day previous.

Dr. Loos was chairman of Reference Committee No. 3. He introduced that document in the first meeting of the 1950 session on the Sunday evening meeting, and he announced that there would be an opportunity to add amendments to it at the Tuesday, or second, meeting. This is in accordance with Robert's Rules of Order, and also with the provisions of our own constitution, which require that a proposed constitutional amendment must lie on the table for one year before it can be voted upon.

As a matter of fact, there were introduced two amendments to the document, now lying upon the table, by Dr. J. E. Young of Fresno.

Reference Committee No. 3 also held a pre-convention hearing yesterday and they spent a lot of time on it, and a number of you people were present at that hearing. They have something to report for you at this time.

The chair recognizes Dr. Lyle Craig, chairman of Reference Committee No. 3.

REPORT OF REFERENCE COMMITTEE No. 3

DR. LYLE G. CRAIG: Mr. Speaker and members of the House of Delegates: Your Reference Committee No. 3 has held hearings on the proposed constitution as presented to the House of Delegates in 1950 and at present lying on the table. It is the result of four years of study by several committees and represents a considerable improvement on the existing constitution. Its chief advantage lies in the fact that it is a more flexible instrument than the present constitution, which contains a great many details which have been omitted from the proposed new constitution and which will be placed in the by-laws, where they can be readily changed at the will of the House of Delegates during any session without the delay incident to amendment of the constitution.

The adoption of this constitution will require new by-laws, which the committee is prepared to present immediately if this constitution is adopted, and the new by-laws so presented will have to lie on the table for 24 hours.

Therefore, Mr. Speaker, your committee recommends the adoption of this constitution, and I so move.

SPEAKER ALESEN: Thank you, Mr. Chairman.

Inasmuch as our constitution specifically provides for a vote by the membership and not just on the report of the committee, we merely accept your report as recommendatory.

At this time, members of the House of Delegates, it is in order to debate the adoption of the proposed constitution as it now lies upon the table. Does any delegate wish to discuss the proposed constitution, either for or against its adoption?

DR. E. T. REMMEN (Los Angeles County): Mr. Speaker, members of the House: I was a member of the first committee, the large committee which worked on the constitution. I think that on the whole the constitution as it is before us tonight is a very great improvement over the old constitution, which is old and is a hodge-podge of amendments and patches which have taken place over a 20- or 25-year period. There are three or four little points which may be debatable, but it would be impossible to adopt any constitution as a whole which met with the approval of everyone.

Some of us who were on those earlier committees think that three or four points should be debated, not tonight, but that amendments should be introduced at this time to lie over; amendments dealing with such matters as the exact composition, perhaps, of the House of Delegates, of the Council, of financial controls, and an amendment to the by-laws dealing with life memberships. But those can be taken up next year after thinking about them a year, and either accepted or rejected as the House in its wisdom and the thinking about the matter may decide. It is merely a matter of administrative policy and what is soundest.

So, I shall later introduce those amendments to lie over for a year, and then next year you may either adopt one or all of them, or reject them, as seems best. But I urge that the constitution as it now stands be adopted.

SPEAKER ALESEN: Is there further discussion upon the proposed constitution?

. . . The question was called for. . . .

SPEAKER ALESEN: If not, do you wish to vote?

. . . The question was called for. . . .

SPEAKER ALESEN: The chair will appoint as tellers Dr. James S. Edwards of San Mateo, chairman; Dr. Paul Michael of Alameda, and Dr. Leopold Fraser.

Will the tellers please pass out the ballots. This is ballot number one on the proposed new constitution.

As you know, adoption requires a two-thirds vote of delegates present and acting for its adoption.

DR. WILBUR BAILEY: Mr. Speaker, may we vote by acclamation?

SPEAKER ALESEN: No, Dr. Bailey. We must vote by ballot. We would like to proceed a little more rapidly. However, we can proceed to other business just as soon as the ballots have been passed out. We can go ahead and have the address by Dr. Cass.

At this time, ladies and gentlemen of the House of Delegates, I present Dr. Cass, President of the California Medical Association. (Standing applause.)

DR. DONALD CASS: Thanks, fellows. You are going to be terribly disappointed because I gave my speech this morning. I am not going to give it again.

We have a precedent here, since Dr. Goin didn't repeat his speech, that the president doesn't make any more addresses.

I have a pleasant duty to perform today, however, and that is to award the pin or medal to our members who have been members of our society for 50 years.

I will call off the names and as I call them off I wish these doctors would come forward:

Dr. Elmer J. Couey, Fresno County. (Applause.)

Dr. Lois C. Worthington, Kern County. (Not present.)

Dr. George A. Laubersheimer, Los Angeles County. (Not present.)

Dr. F. M. Pottenger, Sr., Los Angeles County. (Applause.)

Dr. H. O. Howitt, Marin County. (Not present.)

Dr. John N. Baylis, San Bernardino County. (Not present.)

Dr. Harrington B. Graham, San Francisco County. (Not present.)

Dr. Lewis Mace, San Francisco County. (Not present.)

Dr. Emma W. Pope, San Francisco County. (Not present.)

Dr. Lionel S. Schmitt, San Francisco County. (Not present.)

Dr. Harry R. Oliver, San Francisco County. (Not present.)

. . . Standing applause. . . .

* * * * *

SPEAKER ALESEN: From the very nature of the situation, it will be impossible to act upon the amendments to the proposed new constitution until we know the action you have taken upon the proposed new constitution. And we can't, of course, act upon the proposed amendment to the present constitution until the proposed new constitution has been acted upon.

Therefore, while the tellers are performing their duties we will proceed to the next items of business.

The chair recognizes Dr. Sidney J. Shipman of San Francisco, Chairman of the Council.

REPORT OF THE COUNCIL

DR. SIDNEY J. SHIPMAN: Mr. Speaker, members of the House: The Council has two additional items to the report which you have already seen. You may know that an attempt has been made to revive the old EMIC program. The Council believes this is not advisable at the present time and also believes that the C.M.A. should have a positive platform and in view of that fact proposes this resolution:

Resolved, That in view of certain legislation now pending in Congress on the subject of providing medical services for the wives and infant children of enlisted men in the armed forces, the California Medical Association go on record as expressing support of the principle of giving such aid to the families of our fighting men in cases of hardship without, at the same time, creating any interference with the practice of medicine, choice of physician, or with current hospitalization procedures, and wherever possible through the use of existing medical care and hospitalization prepayment plans working within the framework of medical and hospital organizations.

You are also familiar with the Student American Medical Association. The Council has a resolution with regard to this:

Resolved, That the House of Delegates of the California Medical Association express its complete support of the Student American Medical Association and urge upon the component county medical societies their full cooperation with the chapters of this organization which are or will be formed in the medical schools of California; and be it further

Resolved, That the House of Delegates adopt a policy of making available to the California members of the Student American Medical Association annual subscriptions to the official journal, CALIFORNIA MEDICINE, at an annual rate of $1 per year, the additional $2 per year required by postal regulations to be supplied by the Association in its annual budget; and be it further

Resolved, That the adoption of the above recommendation would make the further publication of *Future M.D.* unnecessary, wherefore its publication should be discontinued with the thanks of the Association extended to its editors who have so capably filled the gap during the formation of the Student American Medical Association.

SPEAKER ALESEN: Those portions of the addenda dealing with policy will be referred to Reference Committee No. 1. That portion dealing with recommended changes in budgetary matters will be referred to Committee No. 2 on finances.

Proceed, Dr. Shipman.

DR. SHIPMAN: I proposed this most recent resolution.

William Bender, the son of Dr. William Bender of San Francisco, was kind enough to accept an invitation to come before the Council this morning and give us his experiences with the Student Medical Association.

Bill Bender is a senior at the University of California, and at the recommendation of the Council, has agreed to appear before you. The Speaker has given us permission to do so.

Is Bill Bender here?

A MEMBER: Dr. Shipman, that is my responsibility. I counted on a few more minutes in Dr. Remmen's speech, and I told him he could stay upstairs a few minutes longer.

SPEAKER ALESEN: We will proceed, then, Dr. Shipman, and as soon as Bill Bender comes in, will the chair please have that information?

Next the report of the Trustees of the California Medical Association. Any additional report, Dr. Cass?

DR. DONALD CASS: No further report.

SPEAKER ALESEN: Next, report of the Auditing Committee.

DR. DONALD D. LUM: Nothing further to report, Mr. Speaker.

SPEAKER ALESEN: Report of the Secretary.

SECRETARY DANIELS: Mr. Speaker, no further report.

SPEAKER ALESEN: Report of the Executive Secretary.

EXECUTIVE SECRETARY HUNTON: No further report.

SPEAKER ALESEN: Report of the Editor.

DR. DWIGHT L. WILBUR: No further report.

SPEAKER ALESEN: Reports of District Councilors.

Do any of the District Councilors have anything to report? (No response.)

Reports of Councilors-at-Large. (No response.)

Report of legal counsel, Peart, Baraty and Hassard.

MR. HASSARD: No further report.

SPEAKER ALESEN: Reports of standing and special committees: Executive Committee, Donald Lum.

DR. DONALD D. LUM: No further report.

SPEAKER ALESEN: Committee on Associated Societies and Technical Groups, Robert A. Scarborough.

DR. ROBERT A. SCARBOROUGH: No additional report.

SPEAKER ALESEN: Committee on Health and Public Instruction, Dr. Orrin Cook.

DR. ORRIN COOK: No further report.

SPEAKER ALESEN: Committee on History and Obituaries, Dr. Edmund T. Remmen.

DR. EDMUND T. REMMEN: No further report, Mr. Chairman, except if any of you have any historical material, any photographs of well-known members of the Association, or any material to help Dr. Kress in his history, please send it to the office of the State Association to be forwarded to Dr. Kress.

SPEAKER ALESEN: Committee on Hospitals, Dispensaries, and Clinics, John B. Hamilton.

DR. JOHN B. HAMILTON: No further report.

SPEAKER ALESEN: Committee on Industrial Practice, Raymond M. Wallerius. (No response.)

Committee on Medical Defense, H. Clifford Loos.

DR. H. CLIFFORD LOOS: No further report, Mr. Speaker.

SPEAKER ALESEN: Committee on Medical Economics, H. Gordon MacLean.

DR. H. GORDON MACLEAN: No further report.

SPEAKER ALESEN: Committee on Medical Education and Medical Institutions, L. R. Chandler. (No response.)

Committee on Organization and Membership, Carl L. Mulfinger.

DR. CARL L. MULFINGER: No further report.

SPEAKER ALESEN: Committee on Postgraduate Activities, John C. Ruddock.

DR. JOHN C. RUDDOCK: No further report.

SPEAKER ALESEN: Committee on Publications, George Dawson.

DR. GEORGE DAWSON: No further. (Laughter.)

SPEAKER ALESEN: That certainly is representative of an economy of words. Thank you, Dr. Dawson. (Laughter.)

I know the next gentleman is going to have a report that is very interesting to every member of the House of Delegates. I can vouch for it.

Committee on Public Policy and Legislation, Dr. Dwight H. Murray.

Now, in introducing Dr. Murray I would like to say just a personal word. Dr. Murray is one of the outstanding workers of the California Medical Association. He is in Sacramento on behalf of the California Medical Association. He is in Chicago on behalf of the American Medical Association. He also goes to Washington, and in between times he attempts to practice medicine.

Dr. Murray, would you tell us about the wars on the political front? (Applause.)

REPORT OF COMMITTEE ON PUBLIC POLICY AND LEGISLATION

DR. DWIGHT H. MURRAY: Mr. Speaker, members of the House of Delegates, and guests: I am very glad to report to you again that the legislative session of Sacramento is halfway through. So far there has been no adverse legislation passed, but remember that the last half is always the hardest; in the last mile, you know, the going really gets tough. So, don't expect too much in the last few days.

At this time I want to take the opportunity to thank the members of the Legislative Committee, and also the men who really answer the bell. That means Ben Read, Ed Clancy, Hap Hassard, and John Hunton. That is quite a team, and when they

get into action, something has to happen. Fortunately, it usually happens for the best of medicine.

The Woman's Auxiliary has been very helpful to us at all times and we certainly appreciate the assistance that they give us.

Also, the Legislative Committee could not function if it weren't for the Council and the officers behind us. The Council is more than generous, more than liberal with its views and with its permission for the Legislative Committee to do certain things. I fear sometimes that we may get them into trouble.

I want to tell you about my idea of the general feeling at the Legislature. I have been going to Sacramento now for 11 years, and in that 11 years it seems to me that there has generally been a better feeling between the legislators and the medical profession. But this year it is decidedly better than it has ever been before. Now, that didn't just happen. It didn't just happen because it is 1951; it didn't just happen because of anything except the work that you fellows did at home, and that we appreciate very much.

I can name you dozens of candidates in whose elections you are interested, and that is reflected in their actions at Sacramento.

Now, don't sell yourselves short and don't think that the Legislative Committee of the California Medical Association or any other legislative committee can function without that help at home. Believe me, that is appreciated and the effects are very clearly seen.

When we talk to the legislators about legislative matters they will listen to us. It doesn't mean they will always agree with us, but at least they will sit down and listen to us, and we'll say, "Well, now, perhaps you would like to talk with Dr. Brown, or Dr. Smith down home about it." And frequently that is done.

Now, your two bills are things I want to mention in an over-all way, and I will later call on Ben Read to speak to you about some of the particular bills.

You have perhaps heard quite a lot about the Rehabilitation Bill, Senate Bill 1434, particularly you people in Los Angeles.

That bill first provided that the medical care of the handicapped children, and not only handicapped children but handicapped adults, should be under the Department of Education. We objected to that very strenuously. We felt that the Department of Education had no more business directing the physical rehabilitation than we have of trying to teach the three R's, and they were told so.

They came back to Sacramento after two weeks' time and agreed that we were correct, and told us that they would be willing to accept some amendments.

Those amendments were drawn up entirely at our direction, and were entirely acceptable. So that is why the change of pace of the California Medical Association with reference to the rehabilitation bill. That is the reason, gentlemen, that it is very difficult for your Legislative Committee to keep the various county legislative committees informed on what is going on.

I have been asked several times, "Can't you tell us what is going on? Can't you tell us the status of this bill or that bill? Can't you direct us a little about this or that?"

It is impossible to do so in advance because we may have to retract some statements, and I think we had better not make a statement than to make one and have to retract it.

If at any time any of you wish to know anything about the status of any particular bill, call some member of the Legislative Committee. You may call Ben Read, Ed Clancy, John Hunton, or myself, and we will try to give you the exact status of the bill at that particular moment.

The Board of Medical Examiners had a number of bills and we were very glad to have them ably presented by the president of the Board of Medical Examiners, Dr. Bailey. He made two trips to Sacramento. We are sorry to have to ask him to do that, and when I first spoke to him about it he had this complaint and that complaint and this excuse and that excuse, but none of them were any good, and he came along like a gentleman and did a masterful job.

We are having quite a little difficulty at the present time, and I know a great many of you are aware of this, with the pharmacy bills, with particular reference to the dangerous drugs. Now, there are a great many bills, and I shall not attempt to tell you, but Ben Read will tell you something about some of the particular bills in a few minutes. It is just impossible for us to keep you informed because the situation is changing all the time. We will talk to an author of a bill and he will decide to withdraw the bill, or we will talk to him and he will decide on certain amendments; so it is ever changing, and that situation has been a bit troublesome. I hope we may get it ironed out to the satisfaction of the pharmacists and the medical profession.

One bill that created quite a lot of tension was the bill on animal research. You might call it "The Old Dog Bill," or you might call it most anything you want. I have heard it called a lot of things. (Laughter.)

Anyway, this animal research bill provides that the laboratories doing animal research shall be licensed and inspected by the Department of Public Health. There was a great deal of argument about it one way and the other among different people in the profession, but I wish to thank the deans and faculties of all medical schools that supported us on this bill. All of them came to Sacramento at a specified time. Some of them came twice.

I think I should tell you this one particular experience, not necessarily because of the personalities involved, but to show you really the political power, if you please, of the medical profession.

This animal research bill was to be heard in the Senate before the Committee on Public Health and Safety. These faculty members of all the medical

schools were there, and also the dean of the school of veterinary medicine at Davis, Dr. Hart. We had breakfasted together that morning and we had programmed the meeting. It was decided that Dr. Kerr would make the presentation. When Dr. Kerr stepped around in front of the committee to speak, the chairman of the committee said, "Gentlemen of the committee, I wish to state to you that I wouldn't be here today if it weren't for Dr. Kerr. Dr. Kerr saved my life."

You could readily understand that there was no difficulty getting that bill through the committee. (Laughter.)

Now that, perhaps more times than you gentlemen know about, brings results. I like to tell you these things, and I would like you to know and to feel proud of the fact that you do have a certain amount of political influence, every one of you, and please don't forget to use that when the proper time comes.

I can't thank you too much for such cooperation and such spirit as that because, as you well know, the thing that would please our opponents most would be to have a rift or a split in our group. That would mean to them certain victory.

Now, on the national front I wish to say a few words about some of the bills and some of the feelings in Washington. Don't think for a minute that they are not trying just as hard as ever to pass socialized medicine in some form or another. I was talking with Dr. Goin about it yesterday and it reminded me of when we were kids. We had these animal cookies and we would want to save these cookies, you know, and we would take a little bit here and a little bit there and pretty soon the whole animal was gone.

Now, that is exactly what they are trying to do in Washington at the present time. They have realized finally that the direct approach is not practical; neither is it popular, nor has it been successful. Consequently, they are trying some other method of approach, and that we find best in Senate Bill 337.

Senate Bill 337 is the one that provides for federal aid to medical education. The Administration is more anxious to have that bill passed than any other bill on the calendar pertaining to public health and welfare. They are doing everything they possibly can.

Now, unfortunately, there is not a united front in the profession about this entirely because some of the deans in some of the medical schools—you know there are 79 medical schools in the United States—some of the deans in these schools feel there is an opportunity to get some easy money, federal money. Why not get it?

Well, let's be certain about the control of it. There has been a decision handed down by the Supreme Court that says that that which the federal government subsidizes, it will control. So I don't think that it is possible for the medical schools to accept federal subsidy without federal control and, gentlemen, that is why we are opposed to this bill. That is why the American Medical Association started with an appropriation of $500,000 to aid medical schools, and why the California Medical Association put in another $100,000.

Gentlemen, I want to tell you that $100,000 may seem like a lot of money to you, but you never spent $100,000 in a better way than that. The comment that that has caused, not only among people away from California but, if you please, with your own California legislators in Washington — that has pleased them very much and they are very happy and proud of the fact that the California Medical Association is willing to back up its ideas with money.

I can't thank you and compliment you too much on that action.

Now, for the bills with regard to the care of maternity cases. You heard Dr. Shipman speak about it. It is our purpose and intent to try not to have the old EMIC program fostered on the medical profession as it was about five years ago. If there is anything that we can do to prevent it, and I think we can, it will be done. Any resolution that will come from this meeting here with reference to that will be greatly appreciated by the Legislative Committee of the American Medical Association.

Now, Mr. Speaker, I should like to have Ben Read speak to you and explain some of the bills that we have been hearing in Sacramento.

SPEAKER ALESEN: Thank you, Dr. Murray. (Applause.)

Mr. Ben Read, will you please come forward?

We don't need to introduce Ben Read any more than we do men like John Cline, Vince Askey and Lowell Goin, who have done a lot for the California Medical Association in the past years.

Mr. Ben Read! (Applause.)

MR. BEN H. READ: Mr. Speaker, Mr. President, officers and members of the House of Delegates: As Dr. Murray has told you, we are now engaged in the fastest session of the Legislature that I have ever seen, and that goes, I think, for all the observers who have been to Sacramento. In fact, things are moving so rapidly that one of the old-timers in the Legislature said the other day he is now taking only a quick straight drink because if he stopped to drink a highball, two bills would pass during that period. (Laughter.)

As of Thursday night, 5,246 bills have been introduced in the Legislature, and we have found, as usual, that about 10 per cent of them refer to you and your problems.

As Dr. Murray has told you, we are happy to report that as of today no legislation considered adverse to your interests has passed, and many measures that you have sponsored have been passed and some of them signed into law. However, things can change very rapidly in the closing days of the legislative session, and we are keeping our fingers crossed in this rapid pace to make sure that something does not slip by.

I want to make this as brief as possible. As I started forward some man in the back of the room

asked me to make it very short, and I will try to do so, but I do think that a few of these bills should be brought to your attention, and in order to save time I have grouped the subjects alphabetically.

Dr. Murray told you about the bill on animal experimentation. I would like to tell you that a group of fanatical anti-vivisectionists is still opposing that bill, and they are flooding the members of the Legislature, urging them to defeat it. It is Senate Bill 1671. It is now on the inactive file of the Senate because it must await the passage of the budget. But if you have an opportunity, will you please address a communication to your member of the State Legislature, urging him to support Senate Bill 1671.

There are a number of bills which would make chiropractors physicians and surgeons by law rather than by education. We are watching those very closely. None of them has been, as yet, set for committee hearing but we do anticipate there will be our usual battle on those suggestions.

Assembly Bill 1541 sponsored by the Department of Public Health is an effort relating to the regulation of clinical laboratories, technologists, technicians, and so forth, and has been approved by the Assembly Committee on Public Health and the Committee on Ways and Means because it carries an appropriation, and now is on the inactive file of the Assembly again awaiting the passage of the budget.

That bill was opposed by chiropractors when it was presented in the committee, and it will again be opposed by them as it progresses through the Legislature. But I noted particularly that pathologists were interested in that bill, and we are watching it, and we hope eventually it will pass.

Dr. Murray has told you there are several bills relating to dangerous drugs. That is a big subject and a hot subject, and it breaks out in the newspapers every few days, as you know. The federal authorities and some of the state and county authorities who are almost fanatical on the subject are clamoring for certain legislation. In fact, one of the members of the police department told me they were going to demand that any time a sedative is given to a person, or one of the dangerous drugs, hypnotic drugs, it should be given only by the physician.

I said, "Do you mean that if the hospital calls late at night and says, 'Doctor, Mrs. So-and-so can't sleep, should I give her something,' should the doctor get up and go to the hospital and give that to her?" He said, "Yes, that is what we intend to insist upon." (Laughter.)

We don't want, naturally, to throw down the bars, but we do want what we thought we were getting in 1949, when all parties agreed to amendments to the Dangerous Drug Act, and they were passed. But there were some interpretations by the Attorney General's office which changed that. There are about half a dozen or so of those bills. They are now in a subcommittee of the Assembly Committee on Public Health headed by Assemblyman Byron Rumford, a Berkeley pharmacist. We are meeting next Monday to attempt to work out a bill to help you to carry on your practice as you have in the past, but at the same time to try to stop any leaks, and we are really going to have to do some work on that one.

Disability insurance, of course, is a subject that we have to watch very closely. You know that the employed person pays one per cent; one per cent of his salary or wages is deducted and sent in to the State Disability Fund. That is to pay him when he is ill and cannot work because of illness. The part that you as the employer pay in to this state fund goes to pay the man when he is out of work and can't find a job, but his own one per cent is frozen purely and simply for relief when he is ill and cannot work.

At the present time he gets $25 a week and he gets $8 a day for 12 days if he is confined in a hospital under the direction and orders of a doctor.

Now, that fund has been increasing; two years ago there was $80,000,000 in reserve and today there is $102,000,000. As the fund increases, naturally there is a desire on the part of labor and some political groups to pass that money out. They say, "The man paid it, why shouldn't he have it?" So, there are bills before the Legislature. One would raise the amount of weekly pay the man receives, when he is sick and cannot work, to $35 a week.

There is currently an attempted agreement between insurance companies and labor upon that figure, but business said it was not consulted. Certainly you were not consulted, and other groups were not, so there is some opposition to it.

It looks now like that figure might be raised to $30 a week and some other changes made.

There are also some bills to increase the hospital benefits, and we understand that the Governor expects to urge the Legislature to pass a bill which would give the individual $12 a day for 20 days when he is confined to a hospital under the orders of a physician. The theory is that he will use that for paying his hospital bills, but we understand from a great many of the hospitals they have not yet received these funds they have been paid in the past.

It is difficult for us to oppose that because it is the workers' own money. Yet it is simply another little foot in the door, or the toe in the door, and with that $102,000,000 up there we are frequently told there is quite a movement for use of that fund to give every employed person an annual physical examination; that that would stop everything. And then the next move would be, of course, that there wouldn't be enough doctors to do it, so the state should set up some traveling teams of doctors or something; then you are off to the races with the really socialized medicine program. So we have to watch carefully the 100 or more bills introduced on this subject of disability insurance.

This year the Governor has sponsored a new category of state aid with federal contributions, for totally and permanently disabled persons. They passed a bill to give aid to those people. I think the figure in California is $75 a month for permanently

and totally disabled. There are various figures on that in California. Anyway, business opposed it and the County Supervisors and State Chamber of Commerce opposed it before the Legislature, but their opposition was of no avail and the bill is now out on the floor of the Assembly. It opens up an entirely new field in California.

To date no effort has been made to move the A. F. of L.-sponsored compulsory health insurance bill. That is the same bill that has been before the Legislature in the past, and at the present time it is still sleeping in committee, where we hope we will be able to keep it.

An interim committee on insurance headed by Assemblyman Geddes has introduced Assembly Bill 2693, aimed at controlling insurers who offer fantastic benefits and fail to produce; these rackets you hear on the radio. That has passed the Assembly and is now in the Senate Judiciary Committee. It is meeting violent opposition from some groups.

There was a bill to set up licensure for masseurs. I guess the members of the Assembly Committee thought they would like to study these massage parlors for a couple of years, so they sent that to an interim committee.

No bills considered detrimental to the ethical practice of medicine have passed the Legislature to date. A series of bills sponsored by the State Board of Medical Examiners and the C.M.A., to make some needed changes in the Medical Practice Act, have passed the Legislature and have been signed into law by Governor Warren.

For some unknown reason much uninformed opposition has been aroused by fringe groups to Assembly Bill 2672, which would define "diagnose" and "diagnosis," and to Assembly Bill 2673, which would make the third conviction of the violation of the Medical Practice Act a felony. These bills have passed the Assembly without opposition and are now in the Senate Committee on Business and Professions.

I think a lot of you heard that number which would define "diagnose" and "diagnosis." We don't know why the opposition came up so violently to this. We think it was aroused by fringe groups.

There was some legal opposition from the State Department of Motor Vehicles who thought the testing of drivers might be considered as "diagnosis," but amendments were offered to amend that situation and that bill is out of the committee and on the floor of the Assembly for final action.

The State Department of Mental Hygiene introduced an attempt to permit unlicensed practitioners of medicine to practice in state mental institutions for a period of five years. About 1941, I believe it was, a bill was passed to the effect that a person licensed in another state—which state meets California qualifications—may come to this state and apply for a right to take the examination and then practice for a period of one year in a state institution under the direction of a physician and surgeon licensed in California.

Well, that has been in existence for about 10 years, and still the department says they can't get enough doctors in these institutions. They came up with a proposal that they be allowed to practice five years without a license. We couldn't see why the poor individuals locked up in institutions should be exposed to these individuals who were not licensed in California when they were not good enough to practice on the general public, so we opposed that, and that bill at the moment is dead.

Senate Bill 1602 relating to the employment of physicians and surgeons by licensed charitable institutions, foundations, clinics, or by approved medical schools operating clinics, if there is no charge for the professional services rendered, has been signed into law by Governor Warren.

There is quite a little dispute on between the surgical supply houses and the Pharmacy Board relating to the activities, or what the surgical supply houses can do. The Pharmacy Board wants to require them to have a registered pharmacist on duty and they cannot continue to sell certain supplies to you as they have in the past. The surgical supply houses want to continue as they have have in the past. The California Medical Association has taken no action on these bills, but we have had numerous calls and letters from physicians throughout the state urging that the situation remain in its present status, that it remain in status quo.

On Thursday the bill which would have set up a State Board of Hearing Aid Examiners was tabled in the Senate Committee.

Next Thursday morning we again will have before us the old perennial bill to set up naturopathic examinations, and to license naturopaths, whoever they are, with all the rights of physicians and surgeons in California. We have defeated it in the past and we hope we will be successful again next Thursday.

We had our annual tussle with the optometrists. The Federal Aid program for the blind which was contained in HR 6000 requires that a person who makes application for blind aid must have a certificate from a physician skilled in diseases of the eye, or an optometrist; and California, in order to get the $3,000,000 which is coming, which it expects to get from the federal government, must meet that federal definition; but the bill as introduced in California went further and would make the optometrists do things we thought beyond their field, and we opposed them in that. As a result, the bill that will be carried through is only a minimum bill to meet the federal requirements, which is the best we could get out of it.

The subject of physical therapy started out to be one of the hottest subjects in the Legislature, and there was Assembly Bill 626 sponsored by the C.M.A. and the American Association of Physical Therapists, working under the direction of physicians, to be registered. This was violently opposed by people who perhaps are not so fully trained as the members of the American Association of Physical Therapists, but it has passed the Assembly and is now in the Senate. That bill, contrary to all the

misinformation, does not put anybody out of business. Anyone who wants to practice physical therapy as he has in the past will be able to do so.

I think some of you have heard about this move to set up a State Board of Psychology Examiners to license psychologists. That is another hot bill before the Legislature. You have a group of persons calling themselves psychologists who want such a bill, and on the other hand you have the California Psychology Association, the State Department of Mental Hygiene, and many other groups opposing it because they don't see the necessity of setting up another board on the fringes of the healing arts. That bill came up for hearing about three weeks ago and it was so poorly drawn it didn't even have a definition of psychology in it. The committee told the sponsors to write it over, and it will be up for hearing next Wednesday afternoon.

Dr. Murray has told you about the rehabilitation bill.

On the workmen's compensation subject, there were about one hundred and some bills introduced, and we had to watch every one of those carefully because any one could be amended to affect you. Labor and employers finally reached an agreement, and the agreement is to the effect that all bills should be dropped on that subject except one master bill which would raise the temporary benefit to $35 a week, death benefits from $6,000 to $7,000 in case of a widow only, and from $7,500 to $8,700 for a widow with dependents. Dentures and eyeglasses are to remain as they are at present. On that basis all the other bills relating to workmen's compensation were dropped, which was a relief to us.

One more brief subject, Senate Bill 802. As many of you have heard, it aroused considerable opposition over the state because in its original form it would have restricted you to supplying your patients with only emergency remedies, just the remedies for actual emergencies. There was considerable opposition to that because your patients wanted the thing you wanted; you supply the drugs you think they need. You want it to remain as it is now. There was opposition from quite a few of San Francisco physicians who took the time to come to Sacramento, and there was opposition all over the state; so much opposition that the author of the bill, Senator Kraft, withdrew it. This was one of a series of three bills he had on the subject, and no direct action has been taken on any of them.

Thanks to the vigorous opposition of veterans in the San Francisco and Los Angeles areas Assembly Bill 2187 was taken off calendar by the author. This was a bill of about four lines, and it provided that any person who made application for the right to take the examination of the Board of Medical Examiners could take that examination if the school from which he graduated was accredited and approved at the time his application was filed, not at the time he graduated, which is the present law. There was an inference that the veterans wanted this. The veterans throughout the state quickly showed the committee, they did not agree with this belief.

In the closing days many things can happen to bills, and we have to be very careful regarding them. But before I bring this one little matter to your attention I want to tell you that your colleagues in Sacramento do a tremendous job in helping us with our legislative work. One hundred twenty members of the Legislature and their families are away from their homes, and they are in Sacramento hotels and apartments for a period of six months. They develop a great many ills at all hours of the day and night, and the Sacramento physicians have been very cordial and cooperative at any time we have called upon them to get up at any hour of the day or night to take care of the members of the Legislature. That is very valuable assistance to us in our work.

Now, just to show you an example: Assembly Bill 3033 was introduced January 23, 1951, and went to the Committee on Boards and Commissions. At first glance we wouldn't pay any attention to it because we never have bills before the Committee on Boards and Commissions.

It was an act to amend certain sections of the Alcoholic Beverage Control Act, relating to the State Board of Equalization.

We have not had anything before relating to the State Board of Equalization, but on May 8 there was an amendment added away over on the last page, an amendment to the Business and Professions Code, which I would like to read to you. I do this to show why we have to be on our toes. Remember, this is the Alcoholic Beverage Control Act that it amends:

"The procuring or aiding or abetting or attempting or agreeing or offering to procure a criminal abortion constitutes unprofessional conduct within the meaning of this chapter; but no license shall be suspended or revoked for a violation of this section upon the uncorroborated testimony of the woman upon or with whom the offense was committed."

There is an Alcoholic Beverage Control Act amendment, and now it is an amendment to the Medical Practice Act. That shows you why we have to watch very carefully over 5,000 bills. (Applause.)

SPEAKER ALESEN: Ladies and gentlemen of the House of Delegates: It is a pleasure to present Mr. William Bender to you. We heard this young man this morning give an excellent presentation. He is a senior medical student of the University of California. Like father, like son; Mr. William Bender. (Applause.)

MR. WILLIAM BENDER: Mr. Speaker and members of the House of Delegates: I was originally asked by Dr. Shipman to say a few words to the Council at breakfast this morning about the newly formed Student American Medical Association. I gave my speech about it, a few personal observations, and was then cross-examined for a quarter of an hour by various Council members; then was informed I would speak before the session here this afternoon. So, I am not too well prepared, but will try to give you the main ideas of what we are doing here.

I will divide my speech into two parts: First, a discussion of the Student American Medical Association, then some personal observations.

As you may remember, two or three years ago a member of the House of Delegates of the American Medical Association suggested that the American Medical Association sponsor and help form a student organization. Basically he was worried about the only existing medical student house staff organization, and that is the Association of Interns and Medical Students, AIMS. At that time it was pretty well infiltrated with communists. Two of its top officers went to the Budapest peace parade sponsored by the communists, and very vocally and loudly proclaimed Russia and her satellites in the usual communist style. So, the American Medical Association went ahead to start up this organization of the students.

I was sent to Chicago as Dean Smyth's representative last year. There were 47 schools represented there. All the medical schools were sent invitations. Approximately half of the medical students there represented organizations that had already been formed on their own campuses, which would become part of the Student American Medical Association. The others were personal representatives of the deans of the various medical schools.

The most immediate problem that came up was that the students wanted to know from the American Medical Association just why the American Medical Association wanted to start that organization. Dr. Lull in his introductory address to us, made the best statement, I think, as to why the American Medical Association wanted to have it, and that is that 75 per cent of the doctors of the United States are members of the American Medical Association. It follows, then, that 75 per cent of the medical students will probably become members of the American Medical Association, and it behooves the students to know something about the American Medical Association, so that when they become active members of their local societies and the American Medical Association they will be able to take an active interest in it.

While there we wrote a constitution. We elected officers, and planned programs of what we were going to do in the future. I will read off some of our ideas on our program. Most of them are beginning to function already.

We are investigating health insurance for medical students and their families on a nationwide scale. We are trying to set up nationwide internist information written by informed and interested people other than publicity agents for the hospitals. (Laughter.) I stress that because I am a senior student and I got a lot of information from the hospitals on how good they were and found out they weren't very good.

We hope to get reduced rates for books and supplies on a nationwide scale for students.

Surprisingly enough, we are getting out a student journal which we hope will be self-supporting through advertising and that will be out around October 1.

We are trying to promote a program for undergraduate research funds for medical students.

We hope to get reduced rates for the American Medical Association *Journal* for medical students.

We are trying to get summer placements in a kind of clerkship affair for the medical students on a nationwide scale.

Going on to our local situation here in California, we have four medical schools. I think I will start with the worst and get up to the good part, so I will start with Stanford. (Laughter.)

Stanford was invited to go this national convention, but it didn't send a representative. Dr. Cheney of the San Francisco county society became interested in our chapter at U.S.C., and the student officer of the Student American Medical Association contacted the dean of that university and got a "Well, we will wait and see" attitude. This is a quote from one of the letters I have gotten. So, no help there. Stanford doesn't have an organization and it doesn't look as though it wants one.

U.S.C. was represented in Chicago. The student who is trying to start up the Student American Medical Association there has had trouble getting beyond the student body and the newly formed Student Council. Both of them wanted to wait until their own organizations were more stable.

He felt that by December of 1951 his organization would probably be running and he would be able to send a delegate at that time.

The College of Medical Evangelists is more or less in the same situation, but I think we will be able to have its organization working in a short period of time.

In a poll of the upper class, 108 out of 150 signified they would very willingly become part of the Student American Medical Association. The main hindrance here is the distance between Loma Linda and the Los Angeles County Hospital, which divides up the four classes.

I would like to come to the University of California now, since that is my alma mater. We have a membership of 120 members out of a possible 150 students. I think that is pretty good, considering that the University of California is a hotbed of socialists and economists, if you look at it that way.

One of the big selling factors for membership in our organization was through the California Medical Association. By contacting Dr. Shipman and Dr. Dwight Wilbur, we were able to get a reduced rate for the students for the journal of the California Medical Association at $1 a year, and the California Medical Association will underwrite the rest of it. This makes our dues $2 a year, and I will willingly admit that over half the fellows who joined our organization, approximately 60, joined it for the journal alone. That is to be expected.

Our plan is to set up meetings, probably monthly, in which we will have guest speakers coming from outside the state, through the San Francisco County Society, who are going to come and talk to the

society. We will have them for an afternoon, and they will also talk to the medical students at the university.

In addition, we hope to have monthly meetings and have outside doctors come in to tell us how to pick out secretaries and keep books, things we don't learn in medical school. (Laughter.)

We have a program at Cal, and probably the most important part of it is to get insurance to cover medical students when they are out of school. Just this winter we had a medical student who almost had to drop out because of a skiing accident and the hospital bills were pretty steep. That is just an example.

We, at Cal, are covered as students during the school semester, but not otherwise; also insurance for the families of medical students.

We are going to participate in the intern information, summer placement, and things like that. We hope to have presentation of research papers by the students. I think that is a good point.

We have an advisory board of five members set up by the national constitution. They are: Dean Francis S. Smyth's choices: Dr. Herbert Johnstone, Department of Tropical Medicine, University of California Hospital, San Francisco 22; Dr. Ralph Byron, Cancer Research, University of California Hospital, San Francisco 22; Dr. John Adams, Department of Neurosurgery, University of California Hospital, San Francisco 22. San Francisco County Medical Society: Dr. Orville Grimes, Department of Surgery, University of California Hospital, San Francisco 22. California Medical Association: Dr. William Donald, Cowell Hospital, University of California, Berkeley.

Just one more thing as far as the Student American Medical Association at Cal is concerned. We will presently ask C.M.A. for some funds to send a delegate to Chicago for the annual convention, and that will be in December of this year.

Now it comes to my second part, personal findings and observations. I think Dr. Murray said this is where I am supposed to lift the delegates off their seats.

In presenting the Student American Medical Association to the students, I happened to mention the American Medical Association. I want to tell you that I was very loudly and vigorously booed when I mentioned the American Medical Association. That is the way the students feel about it at Cal.

I can give some reasons for it from discussing it with the students. I think the main reason why the American Medical Association is severely criticized by the students is that they have had no positive action, at least in the students' minds, towards socialized medicine. And they cite back in the '30's when the American Medical Association denounced private insurance plans, and they just keep bringing it right up until the present day.

There is no positive action; all negative. At least that is what the students think.

I also want to say along with this, and this was asked me by several Council members, I think the majority of the students in the senior class of the University of California are for socialized medicine in one form or another. Why are they? I was asked that, too. It is pretty hard to pin it down. I think the main reason is that we have come out of a war in which the national trend, the trend throughout the world, is socialization, and these future doctors are part of that trend.

Another reason is that the majority of them come from the University of California at Berkeley, and U.C.L.A., and they certainly get their full of socialism there. There is no doubt about it.

I was asked whether the socialistic ideas are more intensified in the freshman year or the senior year. I definitely feel it is more intensified in the third and fourth years at the University of California, and I think the main reason is going through the County Hospital in San Francisco and seeing those poor people there get the kind of treatment they do; the sympathy just comes out. Even though it is a form of socialized medicine now, that is the way the students feel.

I have another point here. Somebody asked me about *Future M.D.*, what the students think about that. When the first edition came out I was abused, and I am still abused and insulted because of it, because I, more or less, and a few other in the class represented the American Medical Association's viewpoints. They were insulted. They don't read the magazine any more. It goes right in the waste paper basket. They were insulted. How could anybody think they were that immature!

I think along this line of socialization I can illustrate it further as I did in the Council meeting this morning. How do I think the students are for socialization? Well, I can tell you that the majority of the students at the university medical school are in favor of Truman's administration right now as compared to MacArthur and the dispute going on. In other words, they are in sympathy with Truman. I think that is as good an illustration as I can give you.

Along the same line, in a poll of Harvard medical students a few years ago, they were offered a proposition that if they were given $800, $900 a month for the rest of their lives working as an M.D. for the government would they accept it, and 80 to 90 per cent said they would.

Since I live at home I get my father's viewpoints on the American Medical Association and its aims, and am accordingly sympathetic. The fact that the medical students' viewpoint seems so different may be surprising to you. Perhaps I have been able to convey to you some of the reasons why there are such opinions. It seems to me that, logical as it may be, organized medicine and the medical students are at the present time talking entirely different languages.

It is our mutual problem, and by "our" I mean organized medicine, the students and our own organization, the Student American Medical Association, to provide the machinery by which these two

groups come to understand each other. Thank you. (Applause.)

SPEAKER ALESEN: Thank you, Bill Bender.

Let's proceed with the reports of the standing committees.

Committee on Scientific Work, Albert C. Daniels.

DR. DANIELS: No further report.

SPEAKER ALESEN: Cancer Commission, Lyell C. Kinney.

DR. KINNEY: No further report.

SPEAKER ALESEN: Editorial Board, Dwight L. Wilbur.

DR. WILBUR: No further report.

SPEAKER ALESEN: Public Relations, John Hunton.

SECRETARY HUNTON: No further report.

SPEAKER ALESEN: You have adopted the new Constitution. Yes votes, 219; no votes, 2. (Applause.)

It is now necessary to consider the disposition of the two amendments to the proposed new Constitution, the now existing Constitution under which you are operating. The chair recognizes Dr. Lyle Craig for advice upon those amendments. Dr. Craig!

REPORT OF REFERENCE COMMITTEE No. 3 (continued)

DR. LYLE G. CRAIG: Mr. Speaker: The first of the two proposed constitutional amendments to the new Constitution is printed on page 34 of the Annual Reports Bulletin which is in your hand. It amends Article IV, Section 4, of the new Constitution referring to special assessments.

The only change from the existing provisions is that the penalty for failure to pay such assessment shall be levied by the local society instead of the House of Delegates as printed in the Constitution. Your committee feels such arrangement would not be to the best interests of the California Medical Association, since inequalities would certainly arise and as a matter of policy the penalties as well as the assessment should be uniform throughout the Association. We, therefore, advise strongly that this amendment should be defeated.

SPEAKER ALESEN: The committee's recommendation is that this amendment do not pass.

The Speaker's suggestion is that you would save time if you elected to stand. All in favor that we vote by standing on this proposed amendment signify by saying "aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: You are clear and ready for the vote upon this proposed constitutional amendment. Does anyone wish to discuss for or against before the vote is taken?

Dr. Magoon.

DR. LESLIE B. MAGOON (Santa Clara County): Mr. Speaker, would the chair make it clear whether we are voting on the amendment or whether we are voting on the recommendation?

SPEAKER ALESEN: We are voting on the amendment, Dr. Magoon. A yes vote means the adoption of the amendment under the terms of which the penalty for failure to pay an assessment shall be levied by the local society instead of the House of Delegates where it now resides under your new Constitution. A two-thirds vote is required to pass this amendment.

Are you ready for the vote?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor of this amendment signify by standing.

. . . A standing vote was taken. . . .

SPEAKER ALESEN: It appearing to the chair that the vote is unanimous against it, it may safely be said that the amendment is lost. The chair so rules.

Dr. Craig, proceed, please.

DR. CRAIG: The second proposed amendment to the new Constitution amends Article III, Section 9(b), relating to the composition of the Council. It also is printed on page 34 of the Annual Reports Bulletin.

Your committee held hearings on this proposal. This proposed amendment, by failing to delineate the 16 new councilor districts, will place the Association in the impossible situation of being unable to elect district councilors until after the Council has met and outlined such districts, which delay is not practical because by adopting the new Constitution the incumbent district councilors must be replaced immediately by new district councilors as outlined in the new Constitution. Moreover, it does not repeal nor conform with Section 14 of Article III.

We believe that this amendment is unworkable and, therefore, Mr. Speaker, request that the Speaker rule it out of order.

SPEAKER ALESEN: The Speaker will rule that the amendment is faulty for the reason stated. This is entirely without prejudice for the idea involved, and it is quite possible for those who wish to have their ideas implemented, to do so by introducing a satisfactory amendment at any one of the following meetings of the House of Delegates; such amendment to lie on the table for the necessary one year.

Having adopted the new Constitution, and having disposed of the amendments pertaining thereto, the next order of business is to consider a new set of By-Laws, because without a new set of By-Laws it is very difficult, if not impossible, to operate.

The chair recognizes Dr. Lyle Craig, chairman of Reference Committee No. 3, who will make a recommendation concerning his committee's work of yesterday. Dr. Craig!

DR. LYLE CRAIG: Mr. Speaker, members of the House of Delegates: Since the new Constitution is, as has been stated, a skeleton instrument, it leaves many details which need to be taken care of. It would be impossible for this organization to operate without adopting new By-Laws.

The By-Laws which your committee is presenting are essentially those as printed in the Annual Re-

ports Bulletin with a few changes. These changes are as follows:

A. Page 35, Chapter I, Section 2, Paragraph (c). This has to do with hearings relative to the revocation of component society charges.

This has been cleared to read:

"(c) *Hearing.* Hearing on such complaint shall be held by the House of Delegates at its first session occurring not less than three months after the date of its presentation to the Secretary-Treasurer of the Association."

B. Page 40, Chapter III, Section 2. The last line of the section will change the numeral 4 to 3. This was a typographical error.

C. Page 41, Chapter V, Section 2.

This has been changed to read:

"Commencing with the 1952 regular session of the House of Delegates, each component society shall be entitled to two delegates with one additional delegate for each 50 active members, or major fraction thereof, over and above its first 100 active members as of the first day of November of the preceding year."

Please remember that it is fixed in the Constitution now that the minimum representation from any component society is two members.

DR. LESLIE B. MAGOON (Santa Clara County): Mr. Speaker, at what point will discussion be permitted on proposed changes?

SPEAKER ALESEN: After the report of Reference Committee No. 3, which is being presented. This will be presented to the House as a report, at which time any delegate who wishes to discuss or offer amendments may do so.

Again, when this is adopted later after 24 hours' gestation, there will be an opportunity for amendments to be introduced.

Proceed, Dr. Craig.

DR. LYLE CRAIG:

D. Page 42, Chapter VI. New sections are inserted after the printed Section 2:

"Section 3—Quorum.

"A majority of the voting members of the Council shall constitute a quorum."

That was omitted from the By-Laws and properly should be there.

"Section 4—Meetings.

"a. The time and place of meeting shall be fixed by the Council at a previous meeting and at least 10 days' notice shall be given each councilor by the Secretary of the time and place of the meeting.

"b. The Council shall also meet on the call of the Chairman or upon written request of at least three councilors filed with the Secretary stating the purpose of the proposed meeting. Written notice of the time, place and object of such meeting shall be given by the Secretary to all members of the Council at least three days prior to such meeting."

That is to take care of emergency meetings. Therefore, the following sections of that chapter concerning the Council are renumbered accordingly because of the insertion of two new sections.

New Section 6 (formerly Section 4) of Chapter VI has been changed to read as follows:

"The Executive Committee shall consist of the President, President-Elect, Chairman of the Council, Chairman of the Auditing Committee and Speaker of the House of Delegates."

You will notice that that replaces the other member of the Council.

"The Secretary-Treasurer and Editor shall be members ex-officio, but without the right to vote."

Section 7 (formerly Section 5) of Chapter VI, has been changed to read:

"The Chairman of the Council, subject to its approval, shall appoint an Auditing Committee of three members, delegating one of the members as its Chairman, the duties of which committee are hereinafter specified."

That is because they are hereinafter specified in the By-Laws as presented.

E. Page 46, Chapter VII, Section 19 has to do with the Benevolence Committee. The section is somewhat redundant and verbose, and has been changed to read as follows:

"Section 19 — Physicians' Benevolence Committee.

"The Physicians' Benevolence Committee shall administer those funds of this Association hereinafter designated as comprising the Physicians' Benevolence Fund. These are:

"(a) The funds which may from time to time be allocated to it, from the general funds of the Association by the Council or by the Constitution, are the funds for this committee.

"(b) All bequests, voluntary contributions and donations, from any source whatever, that may be received by this Association for the express or implied purpose of aiding needy members and their dependents.

"Funds contained in the Physicians' Benevolence Fund may from time to time be disbursed by the Physicians' Benevolence Committee."

F. Page 47, Chapter VIII, Section 9 applies to vacancies in office. The last sentence of paragraph (b) shall read:

"Such appointee shall serve until the next Annual Session and until his successor has been elected and has assumed office."

That was to clarify the question as to whether he held office just up to the beginning of the session or not. It gives him the position until he has a successor appointed or elected.

G. Page 48, Chapter IX, Section 3.

The next to the last sentence of the Section has been changed to read as follows:

"He shall, on behalf of the Council, deliver its report to each session of the House of Delegates."

H. Page 49, Chapter 10, Section 4, Paragraph (b).

This section shall read as follows:

"(b) County Secretaries to Collect Dues. The Secretary of each component society shall cause to be collected and shall forward to the office of the Association the dues and assessments for its members, including the annual dues and assessments for the American Medical Association."

If you will refer back to Section 10 of Chapter II you will find that there is something about termination of membership by failure to pay dues, in which it refers to the dues of the American Medical Association. So, this section is made to conform.

I. Page 49, Chapter X, Section 6.

This section shall read as follows:

"All funds and moneys of the Association by whomsoever received shall be promptly forwarded to the Secretary-Treasurer of the Association and deposited by him in a depositary of the Association.

"The Auditing Committee shall inspect all bills and no demands or claims against the Association shall be paid and no funds or moneys of the Association be withdrawn from any depositary thereof except upon written voucher approved by the signature of at least two members of the Auditing Committee or by a majority vote or written approval of a majority of all the members of the Executive Committee on check or draft signed by any two persons authorized by the Council, providing all such authorized signers are under bond."

J. Page 49, Chapter X.

A new chapter is to be inserted immediately preceding the chapter entitled "Referendum and Petition."

There is indirect reference in the paragraph above to surplus funds from the publication, but there is nothing in the chapter as printed to authorize publication.

The new chapter would be Chapter XI, and reads as follows:

"Chapter XI—Publications.

"Section 1—Scientific Journal.

"The Association shall publish and distribute an official journal in the interest of the Association and of its members, devoted to the advancement of medical thought and science, to medical organization, and for the dissemination of medical and public health information.

"Section 2—Annual Directory.

"The Association may publish an annual directory of members, with such other information as the Council may direct.

"Section 3—Pre-Convention Bulletin.

"The Association, prior to the annual session, shall print a pre-convention bulletin, which shall contain reports of officers and committees; provided, that the Council shall have the right to delete or modify such reports, and provided further, that committees whose reports have been deleted or modified shall have the right to submit them to the House of Delegates in their original form if the committee so desire. A copy of the pre-convention bulletin shall be given to each delegate and alternate, on or before registration."

Chapters XI to XIV, as printed in the Annual Reports Bulletin, shall be renumbered XII to XV on account of the insertion of a new chapter.

Mr. Speaker, your Reference Committee No. 3 presents these By-Laws to lie on the table for 24 hours.

We move that at the close of today's meeting this House adjourn to meet again tomorrow afternoon for the express purpose of voting upon these By-Laws and accepting amendments thereto.

SPEAKER ALESEN: This is a motion to fix the time to which to adjourn. It is a privileged motion. You can see the purpose of it, of course; that is, to comply with the provisions of the present By-Laws, that a new set of By-Laws or any amendments thereto must lie upon the table 24 hours. Also, the technique of an adjourned meeting is used in order to meet the requirements of the proposed new By-Laws in that the district councilors must be elected 24 hours prior to the official meeting, the second meeting of the House, which will occur on Tuesday.

Do I hear a second to the motion to fix the time to which to adjourn?

. . . The motion was seconded. . . .

SPEAKER ALESEN: This is not debatable. You understand the reasons for it. You will have an adjourned meeting 24 hours from this time, this being the time at which the By-Laws are presented as a report.

DR. LESLIE B. MAGOON (Santa Clara County): Is it not in order to propose amendments to the Committee's Report prior to its being placed upon the table, sir?

SPEAKER ALESEN: That opportunity will be given the House in just a moment, but because a prior motion has been received we must dispose of that motion in order to proceed in an orderly manner.

All those in favor to fix the time to which to adjourn at 24 hours hence for the purpose of acting upon the proposed new By-Laws and amendments thereto signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: Now, you have before you the report of Reference Committee No. 3, giving the result of its findings yesterday and a proposed new set of By-Laws. That set of By-Laws has not as yet been placed upon the table. It is merely presented to you as a report in accordance with Section 68 of Robert's Rules of Order. It is, therefore, in order for you to take one of two actions: Accept it as such and order that it be filed or tabled for 24 hours, or else discuss and amend it as you see fit.

In the interest of an orderly and smooth performance, your Speaker would suggest that any amendments be not of a controversial nature in order that we may have a good working set of By-Laws.

Tomorrow when and if the By-Laws are adopted there will be plenty of time for any kind of amend-

ments to be offered at that time, but if you wish to amend the report now, you may do so.

Dr. Magoon?

DR. LESLIE B. MAGOON (Santa Clara County): Yes, sir. This may be deemed of insufficient importance to be brought up at this moment, but I think it is section C of the committee's report. That paragraph can be improved in wording without changing its meaning, and I should like to offer an amendment.

That is on the committee's report, the first page. They have headings A, B, and C. This is heading C. It is page 41, Chapter V, Section 2.

I move it be amended to read as follows:

"Commencing with the 1952 regular session of the House of Delegates, each component society shall be entitled to one Delegate for each 50 active members, or major fraction thereof, according to its membership as of the first day of November of the preceding year, provided, however, that each component society shall be entitled to a minimum of two delegates."

I don't believe that wording can possibly be misconstrued, and I think it is a possibility that the wording of the committee's version could be misconstrued. I offer that motion.

SPEAKER ALESEN: You have heard Dr. Magoon's motion to amend. Is there a second?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion?

. . . The question was called for. . . .

SPEAKER ALESEN: Are you ready for the question? Do you understand?

Mr. Secretary, will you read that, please — Dr. Magoon's phraseology?

SECRETARY HUNTON: That would make the section read as follows:

"Commencing with the 1952 regular session of the House of Delegates, each component society shall be entitled to one Delegate for each 50 active members, or major fraction thereof, according to its membership as of the first day of November of the preceding year, provided, however, that each component society shall be entitled to a minimum of two delegates."

SPEAKER ALESEN: Is there further discussion on the Magoon amendment? Are you ready to vote?

. . . The question was called for. . . .

SPEAKER ALESEN: This requires a simple majority to amend by substitution. All in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The amendment is adopted. Section C, page 41, is amended according to Dr. Magoon's phraseology.

Is there further discussion on the committee's report? If not, what is your wish?

Dr. Davis is recognized.

DR. BURT DAVIS (Santa Clara County): Mr. Speaker, a point of information. On this portion regarding the Auditing Committee, is it the intent of the committee that that should apply to all minor expenses of the running of the C.M.A. office requiring two signatures on each voucher, or what?

SPEAKER ALESEN: Dr. Craig, will you answer his question?

DR. LYLE CRAIG: Immediately following that section the next section is entitled, "Revolving Fund," and takes care of that sort of thing. In fact, it takes care of all the regular expenses. Of course, it would be obviously impossible to run any organization without some provision for paying the express company and those minor bills that come up. So, the next section following that authorizes a revolving fund to pay such minor bills.

SPEAKER ALESEN: Are there further questions, or is there further discussion? Dr. Bullis.

DR. RICHARD O. BULLIS (Los Angeles County): Would it be in order at the present time to introduce a resolution changing a section of the By-Laws?

SPEAKER ALESEN: Yes, sir. You may move to amend by substitution or any other way you see fit.

DR. BULLIS: Mr. Speaker, I would like to move to amend one section. I would like to introduce a change in Chapter II, Section 4(c) of the By-Laws, to be amended to read as follows, page 37 on Life Members, top of page, left-hand side:

"Life Members of the California Medical Association shall be elected by the Council on the recommendation of any component county society from those active members thereof who (one) have been active members of this Association for a period of 20 years or more and are more than 50 but less than 60 years of age, and have tendered to this Association a life membership fee of $150, or such other sum as the House of Delegates may from time to time determine; or (two) have been active members of this Association for 25 years or more, and are more than 60 years but less than 65 years of age, and have tendered to this Association a life membership fee of $100, or such other sum as the House of Delegates may from time to time determine; or (three) have been active members of this Association for a period of 25 years or more, are more than 65 years of age but less than 70 years of age, and have tendered to this Association a life membership fee of $50, or such other sum as the House of Delegates may from time to time determine; or, (4) have been active members in this Association for 25 years or more, and are more than 70 years of age.

"Those active members falling within classification four need not be recommended by any component county society, but the Council may not elect to life membership any active member who has ever been censored, suspended or expelled from the American Medical Association, this Association, any State Medical Association which is a constituent of the American Medical Association, or any county medical society which is a component part of this Association, or a unit of any other State Medical Association."

Mr. Speaker, the main reason for this is that most of our county societies now have group insurance plans that require continued membership, and retired membership cuts them out of these plans.

SPEAKER ALESEN: You move the adoption of this amendment to part (c), Section 4?

DR. BULLIS: I do, sir.

SPEAKER ALESEN: Is there a second?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion on Dr. Bullis' proposed amendment by substitution?

DR. E. VINCENT ASKEY (Los Angeles County): May I request how this differs from the old By-Laws which are stated here? May I speak to that a minute? I am not quite clear in regard to it.

This point of our By-Laws has been misinterpreted in the past and is capable of misinterpretation in the future.

If you remember, under the By-Laws previously in force in this Association, it stated, as I remember it, that a man could, at 50 years of age, pay a certain amount and at 60 a certain amount, and it was found by some men that since at that time when our boys were away in the service and our dues were $100 or $150, that if they paid the life membership, which was considerably less, as I remember around $50 or so, they could take a life membership merely by having been 50 years of age and, therefore, they would be life members without paying as much as one year's dues, which the rest of us were paying.

With this in mind, I think it is important that we clarify just what the situation is under the present By-Laws which our committee has studied. I don't know what change Dr. Bullis' suggestion would make. I am sure Dr. Bullis means to do what is right, and I am, therefore, Mr. Speaker, asking for a clarification on that.

SPEAKER ALESEN: Dr. Bullis, will you answer Dr. Askey's question?

DR. RICHARD O. BULLIS (Los Angeles County): Mr. Speaker, as I read paragraph 2(c) in the proposed new By-Laws, those life members elected prior to the adoption of these By-Laws shall remain as such with all the rights and privileges pertaining to such membership contained in the prior By-Laws, but no new life members shall be elected after the date of the annual session of the House of Delegates at which this section is adopted.

My interpretation of that is, Mr. Speaker and members of the House, that there will be no new life members elected after the adoption of this particular section.

SPEAKER ALESEN: Is there further discussion on Dr. Bullis' motion to amend by substitution? Dr. Magoon.

DR. LESLIE B. MAGOON (Santa Clara County): I was a member of both committees that drew up the By-Laws and Constitution, and that is, as Dr. Bullis said, the provision of life membership was deliberately omitted on the grounds that men in their 50's and early 60's who are in active practice have no right to expect permanent life membership in the California Medical Association on the payment of one or two years' dues. We don't start paying dues until we are 30 or 35. If we are going to stop paying dues when we are 50, there will be no one to support our Medical Association or our county societies financially.

If retirement were associated with life membership, we would be in favor, but a man in active practice at 50, I repeat, we didn't feel had any claim on the privilege of life membership.

SPEAKER ALESEN: Is there any other discussion? Dr. Remmen is recognized.

DR. E. T. REMMEN (Los Angeles County): I feel that the matter of life membership is merely a question of how much you pay for it. A great many well-established organizations make it possible for their members to pay a life membership at the time when their earning power is high so that they are not obliged to discontinue their memberships if illness or age or any other factor causes them to be unable to pay their dues.

The recommendation proposed by Dr. Bullis provides that the House of Delegates may at any time fix the fee or the charge. It seems to me what should be done, if it isn't satisfactory, is to amend it to make the charge or the fee for life membership compatible with the life expectancy of the individual obtaining it so he may at 50, if he has enough money, buy a life membership, and that amount will decline as time goes on.

It is only sound business based on actuarial tables, and the only objection I can see to it is the amount charged. It was all right when the dues were lower, but now the dues are high, and it seems to me it could well be amended by the House of Delegates by another resolution raising the cost to whatever is satisfactory to the House.

DR. E. VINCENT ASKEY (Los Angeles County): Mr. Speaker, at the risk of taking more of your time, I see Dr. Bullis' point, and Dr. Bullis is entitled to it. To clarify it, it would seem to me if Dr. Bullis would leave out any specified amount such as $100 and merely say "such fund or such amount as shall be designated by the House of Delegates," that would probably cover the point.

The reason I am bringing that up is this: That if we pass this amendment stating that it shall be $100, it is not probable but it is conceivable it might 500 or 600 of us that would qualify next week, and for $100 would be in for life; whereas the next House of Delegates that might meet later would say it was $500.

I think that if that amount were deleted and left to such amount as determined by the House of Delegates, it would probably be better.

DR. RICHARD O. BULLIS (Los Angeles County): Mr. Speaker, I would be very glad to accept the suggestion and delete a set amount in my proposed change in the By-Laws. However, I am rather surprised to find that there would be any large number

of members of the state society who would be politically disinclined enough to take a life membership which would disqualify them from appearing as an officer or as a member of this body.

SPEAKER ALESEN: Do you wish to offer that as an amendment, or shall we let it stand?

DR. RICHARD O. BULLIS (Los Angeles County): Mr. Speaker, can we change that?

SPEAKER ALESEN: Tell them how you would like to amend it in order to get it in force in the proper way.

DR. RICHARD O. BULLIS (Los Angeles County): By amending it to leave out the fixed amounts that were stated in the proposed change, and have it read, "an amount set by the House of Delegates."

SPEAKER ALESEN: Is there a second to that amendment?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Do you wish to discuss it? Dr. Gibbons, a member of Committee No. 3.

DR. HENRY GIBBONS III (San Francisco County): Mr. Speaker, I would simply like to make this statement: That our committee, agreeing with the thought of the previous committees, felt that the life membership section was unnecessary, and that section on retired membership would be satisfactory to take care of all members, both active and retired, in the society.

SPEAKER ALESEN: There is now before you Dr. Bullis' proposal to amend his own amendment, that is, to delete the fixed amount and leave the assessment in the hands of the House of Delegates.

DR. RICHARD O. BULLIS (Los Angeles County): Mr. Speaker, one thing I would like to reiterate: A retired membership cuts the member out of the rights of group insurance, and that has been my prime reason in bringing this matter up. Group insurance means that you must maintain your membership.

SPEAKER ALESEN: Is there further discussion on this present amendment of Dr. Bullis? That is the amendment to delete. Are you ready for the question?

. . . The question was called for. . . .

SPEAKER ALESEN: All in favor signify by saying "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: There is now before you Dr. Bullis' proposal to amend by substitution the matter of life membership as changed by the amendment of deletion.

Dr. Bailey.

DR. WILBUR BAILEY (Los Angeles County): Mr. Speaker, gentlemen: It seems to me that this is a good idea, but perhaps the insurance companies could change their rules a little instead of us having to change ours.

In France 20 years ago a letter could be carried for 25 centimes. The same letter today is carried for about 25 francs. That is 100 times as much. In other words, the franc has been devalued.

Now, of course, that will never happen to the dollar, I guess. (Laughter.)

I think fixing life memberships, retiring men at age 50 for practical purposes, when they still have a number of earning years and when we have no idea of what might happen ahead, even if left to the wisdom of this august house, is difficult to tell now.

If we put a man out for $150 or $200, maybe 10 years later we will wish we hadn't, but he no longer is a dues-paying member.

I hope we defeat this and persuade the insurance company to change its plans instead.

DR. J. P. SAMPSON (Los Angeles County): May I speak to this?

SPEAKER ALESEN: Yes, sir.

DR. J. P. SAMPSON (Los Angeles County): Mr. Speaker, members and delegates: As Dr. Bullis has so ably said, this is for insurance purposes. All other organizations, the American College of Physicians, and others have a life membership to allow a man during his earning age to put in a life membership; number one.

Number two, it seems to me that if a young man, beginning at the age of 29 or 30, whatever time of his life he begins, supports this organization over a period of vigorous earning power, that during his later years when he knows the dangers of sickness and illness may come upon him, that he should have the right to a life membership in an organization to preserve his insurance for himself and his family. Thank you. (Applause.)

SPEAKER ALESEN: Are you ready to vote now on Dr. Bullis' amendment by proposed substitution?

DR. LYLE CRAIG: Dr. Sampson has just mentioned the life memberships of the American College of Physicians and, of course, those of you who do surgery know the American College of Surgeons has such a provision. But you also know that so many life memberships have been taken there that their income is pretty badly handicapped and they have been asking for more money as contributions. That might conceivably happen to us if, for the purpose of economy, we all took life memberships. I think we should consider what effect it might have on the finances of this Association.

. . . The question was called for. . . .

SPEAKER ALESEN: The pending question is Dr. Bullis' amendment to substitute the provision of life membership for Section C on page 37. All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was lost. . . .

SPEAKER ALESEN: The amendment is lost. Is there further discussion on the Report of the Reference Committee No. 3?

DR. WELLS C. COOK (Los Angeles County): May I call for a standing vote?

SPEAKER ALESEN: Dr. Wells Cook calls for a

standing vote. All in favor of Dr. Bullis' amendment signify by standing.

. . . A standing vote was taken and the motion was lost. . . .

SPEAKER ALESEN: The amendment is lost. There is no question about it.

Is there further discussion on the committee's report, or do you wish now to have it laid upon the table for 24 hours?

DR. JUSTIN J. STEIN (Los Angeles County): Mr. Speaker, members of the House of Delegates: If you will look on page 44 of the Annual Reports Bulletin, Chapter VII, Section 1, you will notice Standing Committees. I wish to propose an addition to the Standing Committees:

WHEREAS, The civil defense activities of the California Medical Association are administered by the Emergency Medical Service Committee which is neither a special or standing committee; and

WHEREAS, There is no Committee on Military Affairs as such; and

WHEREAS, Military affairs and civil defense activities are closely related; and

WHEREAS, The consensus of opinion of those concerned with civil defense is that civil defense is here to stay and permanent civil defense plans must be prepared and kept in readiness for instant use; and

WHEREAS, Civil defense and military activities will be of tremendous importance to the members of the California Medical Association inasmuch as there may exist a state of undeclared war for many years; be it

Resolved, That the Emergency Medical Service Committee be abolished and a new standing Committee on Military Affairs and Civil Defense be appointed by the President of the California Medical Association. The duties of this committee will be to supervise civil defense and problems of a military nature for the members of the California Medical Association.

SPEAKER ALESEN: Dr. Stein, you are moving to add another committee on page 44, Chapter VII, Section 1?

DR. JUSTIN J. STEIN: Yes.

SPEAKER ALESEN: Is there a second to this motion?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion?

. . . The question was called for, the motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The "ayes" have it. The amendment is adopted.

Are you ready now to act upon the committee's report as amended?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: By your action you have ordered that the report as amended shall lie upon the table for 24 hours and shall then be presented to you for consideration at the adjourned meeting of this first meeting 24 hours hence.

That will be 3:00 o'clock tomorrow afternoon in the auditorium of the Edison Company Building across the street.

At that time the order of business will be limited to action upon the By-Laws now lying upon the table, and to any amendments that any delegates wish to offer at that time.

Now, Dr. Donald Lum, chairman of the Auditing Committee, will present the budget as adopted by the Council. Dr. Lum!

REPORT OF AUDITING COMMITTEE

DR. DONALD D. LUM: Mr. Speaker, members of the House of Delegates: I would like to add a word of explanation. This budget has been gone over in detail by the Council. It will be referred to Reference Committee No. 2 and studied in detail by that committee, and then brought before you for study and action on Tuesday.

I, therefore, will not go into the details of the budget, but simply propose the budget for the fiscal year of 1951 to 1952, with an estimated income of $423,000; an estimated expenditure of $411,250.

On behalf of the Council I present the budget for CALIFORNIA MEDICINE with a proposed income for the fiscal year of 1951 to 1952 of $143,250; with an estimated expenditure of $135,750.

I also recommend on behalf of the Council that the dues be set for $40 for the calendar year of 1952.

SPEAKER ALESEN: Thank you, Dr. Lum.

This report will be referred to Reference Committee No. 2. Dr. Stanley Truman is chairman.

Now we come to the matter of reports of special committees.

Delegates to the American Medical Association, Dr. E. Vincent Askey, chairman. Dr. Askey!

REPORT ON DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

DR. E. VINCENT ASKEY: Mr. Speaker and members of the House of Delegates: It has been my honor to be chairman of your delegation to the American Medical Association, and it has also been my honor to follow some illustrious men; Sam McClendon, Dwight Murray and John Cline have been the immediate chairmen previous to my tenure.

I want to say a note of appreciation to your delegation to the American Medical Association. All the members and alternates that you have seen fit to send there have worked in the most able manner that I could envision. There are many things for your delegates to do. I think that if you listen to Dwight Murray and Ben Read you know many of the things that go on in the Legislature that you don't know about, and may I say in all sincerity that that same thing occurs in the American Medical Association.

One of the things which we have been interested in outside of the House of Delegates has been the

public relations that we could, as delegates from California especially, help along. California, as you know, probably was instrumental a good many years ago, at which time Dr. Gilman was President of our Association, in developing a conference of presidents which holds a meeting the day preceding the meeting of the House of Delegates, and which has been a wonderful sounding post for the things that we deem necessary to be considered by the American medical profession.

This year it has been the privilege of your California Medical Association to have a great part in that program which will be held at the Traymore, and we have been honored by having our good Senator Richard Nixon, who will speak on the subject, "A Congressman Looks at Medicine." He will be on the program there, and will be the special guest of the California Medical Association. We feel that it will have a great deal to do not only with the actions of the House of Delegates but with the attitudes which are heard and realized and understood by the public of the United States.

It astounded me, as it did you, to hear the attitude of the medical students. As the American Medical Association, we lately—and I say "lately" because I don't think we did it early enough — we commenced an educational campaign to educate the people as to what things were in medicine. It seems to me with this fine speech that was just given to us by this young medical student we ought to turn our attention now to educate our own people. By "our own people" I mean the medical students and our doctors of medicine.

I want to appeal to you that if you have any desires that you would like to have brought before the American Medical Association, which actions will be mistakenly taken by the public and by our doctors and by the medical students as being wrong, that if you have any ideas at all as to how to remedy this or how it should be brought out, we wish you would bring it before this body for them to direct us as to what they want us to do.

Secondly, as individuals I wish you would carry it to any member of the Medical Association of this state that they, as individuals, have free access to your delegates which you send to the American Medical Association, and we solicit your ideas.

We hope you will help us. Our job is hard. I want you to know that we are going back there; we are going to do what you want us to do to the best of our ability, and I want to thank you very much. (Applause.)

SPEAKER ALESEN: Other special committees, Physicians' Benevolence Committee, Dr. Axcel E. Anderson.

DR. AXCEL E. ANDERSON: No further report.

SPEAKER ALESEN: Advisory Planning Committee, John Hunton.

SECRETARY JOHN HUNTON: No additional report.

SPEAKER ALESEN: C.P.S. Liaison Committee, Dr. Donald Cass.

REPORT OF C.P.S. LIAISON COMMITTEE

DR. DONALD CASS: Mr. Speaker: This committee meeting was too late to get the report into the Pre-Convention Bulletin.

The C.P.S. Liaison Committee was formed on instructions from the House of Delegates a year ago for the purpose of considering and advising as a liaison group between C.M.A. and C.P.S. on questions of policy and other important articles of business. Memberships consist of the President of C.M.A., President-Elect of C.M.A., President of C.P.S., Chairman of the Council of C.M.A., Chairman of the Legislative Committee of C.M.A., and two members to be elected from the House of Delegates.

This committee met in February 1951 and unanimously approved the action of the Board of Trustees in recommending a $4,800 income ceiling level and also approved the Fee Schedule submitted by the Fee Schedule Committee.

SPEAKER ALESEN: This will be referred to Reference Committee No. 1.

Committee on C.P.S. Administrative Changes, Orrin Cook.

DR. ORRIN COOK: No further report.

SPEAKER ALESEN: Committee on Industrial Accident Commission Fee Schedule, Francis J. Cox.

DR. FRANCIS J. COX: No further report.

SPEAKER ALESEN: Committee on Industrial Health, Christopher Leggo.

DR. CHRISTOPHER LEGGO: No further report.

SPEAKER ALESEN: Committee on Rural Medical Service, Carroll B. Andrews.

DR. CARROLL B. ANDREWS: No further report.

SPEAKER ALESEN: This concludes the old business.

We will now turn to new business, and ask the Vice-Speaker, Dr. Charnock, to take the chair.

VICE-SPEAKER CHARNOCK: Under new business you are at this time privileged to present your resolutions, and we will have each delegate come forward and state his name and county and be prepared to present three copies of the proposed resolutions or changes to the section.

There is no discussion on these resolutions at this time. They will be referred to the appropriate committee.

We are now open for new business. Does anyone wish to present any resolution?

Resolution No. 1

DR. ORRIS MYERS (Humboldt County): A resolution to recommend increased diagnostic procedures allowable in doctors' offices by prepaid health insurance plans:

WHEREAS, It is the policy of the California Physicians' Service and of the many health insurance companies to give more coverage for x-ray and laboratory services on registered bed patients in a hospital than on ambulant cases; and

WHEREAS, Physicians are encouraged to place

patients in the hospital for diagnostic studies who could be handled as ambulant cases; and

WHEREAS, The expense of such diagnostic service is thus greatly increased; and

WHEREAS, Hospital beds for bona fide hospital cases are thus made unavailable; and

WHEREAS, This increased cost to the patient results in increased health insurance premium rates, waste of man hours by both employer and employee, and wastes urgently needed hospital space; and

WHEREAS, There has been no apparent effort during the past year on the part of the insurance companies to correct or alter policies to avoid unnecessary hospitalization; now, therefore, be it

Resolved, That the California Medical Association go on record as recommending that all prepaid health insurance companies give office and ambulant cases more coverage for diagnostic procedures in order to eliminate and prevent this growing trend of unnecessary increased hospitalization.

VICE-SPEAKER CHARNOCK: That will be referred to Reference Committee No. 3.

Dr. Justin Stein of Los Angeles County.

Resolution No. 2

DR. JUSTIN J. STEIN (Los Angeles County):

WHEREAS, May 19, 1951, has been proclaimed Armed Forces Day by the President of the United States, as an occasion for honoring the men and women who serve as "Defenders of Freedom," and for renewing the nation's faith in the ideals of peace and freedom which their united efforts will help preserve; and

WHEREAS, The members of the California Medical Association have always rendered the best possible medical care to the Armed Forces and the civilian population; now, therefore, be it

Resolved, That the Secretary of the California Medical Association be instructed to send telegrams to the President of the United States and to the Secretary of Defense that the members of the California Medical Association are wholeheartedly in support of the aims and ideals for which Armed Forces Day was designed.

The members of this Association wish to go on record that they will always maintain the highest standards of medical care for the Armed Forces and the civilian population in time of war and peace.

VICE-SPEAKER CHARNOCK: Thank you. That will be referred to Reference Committee No. 3.

Dr. Ralph Teall.

Resolution No. 3

DR. RALPH TEALL (Sacramento County):

WHEREAS, The House of Delegates of the American Medical Association, at its San Francisco session in June 1950 reexamined the principle of medical ethics that "a physician should not dispose of his services to any hospital, corporation or lay body, by whatever name called or however organized, under terms or conditions that permit the sale of the services of that physician by such agency for a fee"; and

WHEREAS, The House of Delegates at the same time reaffirmed that radiology, pathology, physical medicine and anesthesiology are all integral parts of the practice of medicine; and

WHEREAS, Any physician who performs professional services for a hospital on a salary basis (except solely for teaching, research or actual charitable purposes) for which the hospital charges fees to the public that are unrelated to the salary of such physician, is ignoring the Principles of Medical Ethics of the American Medical Association and the California Medical Association; and

WHEREAS, The enforcement of the Principles of Medical Ethics is primarily the task of the county medical societies; now, therefore, be it

Resolved, By the California Medical Association that each component society be advised to reexamine the practices of its own members in this regard, and to take appropriate measures to eliminate any violation of this ethical principle by assigning this important problem to an appropriate committee for study and action.

VICE-SPEAKER CHARNOCK: Dr. Teall's resolution is referred to Reference Committee No. 3.

Dr. Carson of San Francisco.

Resolution No. 4

DR. DONALD CARSON (San Francisco County):

Be it Resolved, That the new California Physicians' Service fee schedule as was published does not represent an adequate over-all fee schedule, either minimum, average or maximum, for practice in the State of California in 1951, and, be it further

Resolved, That the House of Delegates of the California Medical Association instruct the Council of the California Medical Association to withdraw its approval of said fee schedule and direct a fee schedule committee to continue its work in the field of attempting to find an adequate over-all fee schedule.

VICE-SPEAKER CHARNOCK: This goes to Reference Committee No. 3.

Dr. Donald Carson.

Resolution No. 5

DR. DONALD CARSON (San Francisco County):

Be it Resolved, That the Council of the California Medical Association be instructed to direct the legal counsel to prepare and direct an educational campaign among the members of the California Medical Association on the subject of restraint of trade, to instruct physicians to be better able to carry on their own businesses and activities in county medical societies in accordance with what are called anti-trust acts, and, be it further

Resolved, That the Council of the California Medical Association shall instruct the editor of the Journal of CALIFORNIA MEDICINE to furnish the required space in the Journal for said procedure.

VICE-SPEAKER CHARNOCK: This is referred to Reference Committee No. 3.

Dr. Carson.

Resolution No. 6

DR. DONALD CARSON (San Francisco County):

WHEREAS, United effort on the part of the medical profession in the State of California toward its objectives is essential; and

WHEREAS, From one large county medical society the following questionnaire and answers were obtained:

QUESTIONNAIRE AND RESULTS

	Yes	*No*
Is the new C.P.S. fee schedule (if 100 per cent payment) adequate in your practice as a guide to over-all private practice fees?	349	401
Is this new fee schedule at 60 per cent unit value adequate in your C.P.S. practice under the $3,600 a year bracket?	151	564
Do you favor:		
(a) Continuation of the present unit value payment plan for services rendered to those C.P.S. patients above the $3,600 a year bracket?	180	408
or		
(b) A specified sum for each service rendered according to an indemnifying schedule on C.P.S. patients above the $3,600 a year bracket?	474	130
Do you favor an increase of the income bracket above $3,600 a year in C.P.S.?	162	539
An increase to $4,200?	124	343
An increase to $4,800?	102	373
Do you favor promotion of the unit value type of service plan such as C.P.S.?	250	407
Do you favor promotion of the other form of voluntary insurance—free choice of physician, medical payment insurance—namely, indemnification insurance?	586	107
In your opinion is the purpose of C.P.S.		
(a) To provide adequate medical care for individuals in low income brackets?	557	106
(b) To provide voluntary health insurance for the greatest possible number of individuals without regard to income status?	261	357

What is the estimated percentage of C.P.S. patients in your total practice?	10%	563	40%	11
	20%	158	50%	9
	30%	60	75%	1
(2%–1) (5%–5) (15%–2)				
What is the estimated percentage you could treat and still stay in practice?	10%	158	40%	33
	20%	169	50%	83
	30%	118	75%	10
			100%	24

and

WHEREAS, Mailed questionnaires to members of the California Medical Association is excellent method of gaining statistical information; now, therefore, be it

Resolved, That the Council of the California Medical Association use this method of obtaining the opinion of the profession.

VICE-SPEAKER CHARNOCK: That will be referred to Reference Committee No. 3.

Constitutional Amendment

DR. DONALD CARSON (San Francisco County): A constitutional amendment:

Resolved, Sub-paragraph (c) of Section 9, Part B, of Article III of the Constitution be amended to read as follows:

(c) The President, President-Elect, Speaker and Vice-Speaker.

VICE-SPEAKER CHARNOCK: This will lie upon the table.

Resolution No. 7

DR. DONALD CARSON (San Francisco County): Another amendment to the By-Laws:

Resolved, That the following be added to Chapter XIII, Section 1, as a third paragraph:

A member shall not refer his patients for diagnostic or other procedures to a laboratory or to another physician under such circumstances that a member receives, either directly or by way of a credit or charge account or otherwise, any reward or remuneration on account of such referral.

VICE-SPEAKER CHARNOCK: This amendment to the By-Laws will be referred to Reference Committee No. 3.

At the present moment we have no By-Laws, and we are going to vote on them mañana. So, they will be referred to Reference Committee No. 3 for their opinion.

Do we have any more?

Resolution No. 8

DR. ALBERT G. MILLER (San Mateo County):

WHEREAS, Medical fee schedules are based on estimates and developed more from custom and usage than fact; and

WHEREAS, A sound fee schedule under any insurance program must take into account the cost of all services rendered by physicians; and

WHEREAS, No such analysis of the actual cost of physicians' services has ever been undertaken, including the cost of ordinary overhead; now, therefore, be it

Resolved, That a thorough cost accounting survey of said professional services in California be secured at a cost not to exceed $250,000.

VICE-SPEAKER CHARNOCK: We will refer that to Reference Committee No. 2.

Resolution No. 9

DR. WENDELL OLSON (Orange County): On behalf of the Orange County delegation I wish to present this resolution:

WHEREAS, The Department of Rehabilitation of the California State Department of Education has specifically instructed its personnel to refer their corrective and rehabilitative surgical problems only to those surgeons who have been certified by the American Board of Surgery; and

WHEREAS, The American Medical Association has published on pages 149 and 170 of Volume 144,

No. 2, September 9, 1950, the following statement:

"The American Board of Surgery has never been concerned with measures that might gain special privileges or recognition for its certificants in the practice of surgery. It is neither the intent nor has it been the purpose of the Board to define requirements for memberships on the staffs of hospitals. The prime object of the Board is to pass judgment on the education and training of broadly competent and responsible surgeons, not who shall or shall not perform surgical operations. The Board specifically disclaims interest in, or recognition of, differential emoluments that may be based on certification"; and

WHEREAS, This discrimination by the Department of Rehabilitation of the California State Department of Education is not for the best interests of the ethical practice of surgery by equally skilled and experienced practitioners of the science and art of surgery; now, therefore, be it

Resolved, That this Association, through its proper representative, request the Department of Rehabilitation of the California State Department of Education to desist from its expressed discriminatory policy and instruct them to obtain a list of qualified surgeons and specialists in related surgical specialties from the local county medical association in that area wherein such rehabilitative and corrective surgery is authorized at the expense of the State of California.

VICE-SPEAKER CHARNOCK: That resolution is referred to Reference Committee No. 3.

Resolution No. 10

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, There are many naval and military posts in California located within reasonable distances of established civilian medical facilities; and

WHEREAS, The personnel in these military posts frequently maintain their families in these neighboring communities; and

WHEREAS, A considerable portion of the time of the medical departments of the armed services is required in attending to the dependents of the military personnel and not to active military problems; and

WHEREAS, California Physicians' Service is ideally adapted for entering into a contract with the armed forces to render medical attention to these dependents; and

WHEREAS, Such a contract would efficiently conserve the use of medical personnel within the armed forces and thereby lessen the need for greater expansion of the military program; and

WHEREAS, Similar contracts with the Veterans Administration and with the agricultural workers, to name but two, have established the propriety and precedence for the custom of governmental agencies contracting with California Physicians' Service for medical care; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association encourage, authorize and request the California Physicians' Service to enter into negotiation with the armed forces for contracts whereby the families and dependents of military personnel may be cared for as private patients in the proper fashion by the civilian physicians in the neighboring communities in which they reside within this state; and, be it further

Resolved, That the California Medical Association call the attention to this program of the various other state and national physicians' health plans in order that they be encouraged to enter into similar arrangements.

VICE-SPEAKER CHARNOCK: This resolution will be referred to Reference Committee No. 1.

Resolution No. 11

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, It is now necessary for a licensed physician and surgeon to obtain formal notarization for narcotics records; and

WHEREAS, it has become an established practice in certain governmental documents, the income tax forms, for example, to replace the requirement for notarization by statements subjecting the signator to the penalties for perjury; and

WHEREAS, These records should not require such formality; now, therefore, be it

Resolved, That the California Medical Association delegates to the American Medical Association House of Delegates be instructed to introduce a resolution in that body directing the American Medical Association to seek legislation and/or administrative relief for this annoying obsolete practice. (Applause.)

VICE-SPEAKER CHARNOCK: Referred to Reference Committee No. 3.

Resolution No. 12

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, It is good accounting practice for business organizations to establish the costs required to create the going concern and to depreciate this capital initial cost over an appropriate period; and

WHEREAS, This procedure has met with the approval of the Department of Internal Revenue and is customary; and

WHEREAS, The costs of a professional education are dispersed over a period of years during which there is no income to offset these costs; and

WHEREAS, These costs represent a capitalization charge which thus constitutes a taxable loss to the individual; and

WHEREAS, All occupational training expenses are now neglected in this fashion, now, therefore, be it

Resolved, That the California Medical Association delegates to the American Medical Association be instructed to seek appropriate legislation to authorize the establishment for tax purposes of the costs of all technical and professional training to be amor-

tized over an appropriate period. (Laughter and applause.)

VICE-SPEAKER CHARNOCK: Referred to Reference Committee No. 3.

Resolution No. 13

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, The members of the California Medical Association have promoted the care for crippled children; and

WHEREAS, The promotion of these services should be expanded within the medical profession; and

WHEREAS, The present lay administrative policy causes disinterest, nay, even hostility, to arise among the family physicians who should be the most enthusiastic supporters of the program; and

WHEREAS, This dissension within the profession is not only disadvantageous to the profession but also defeats many of the purposes for which the Crippled Children legislation was originally enacted; now, therefore, be it

Resolved, That this House of Delegates of the California Medical Association disapprove of the interpretation of the Crippled Children Act as it is now directed, in particular the establishment of categories of physicians and surgeons who may or may not attend beneficiaries under the act; and, be it further

Resolved, That the California Medical Association advise the lay directors in the interpretation of the act that the license to practice medicine and surgery, as granted by the state, establishes no classification or further qualification upon the right to practice.

VICE-SPEAKER CHARNOCK: This is referred to Reference Committee No. 3.

Resolution No. 14

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, An analysis of the appropriations for the California Crippled Children Act clearly shows that approximately 95 per cent of the costs are borne by the state and the localities; and

WHEREAS, the federal appropriation establishes certain restrictions on the use of the entire funds so appropriated, local and state as well as federal; and

WHEREAS, Many physicians find these restrictions abhorrent and monopolistic in nature; now, therefore, be it

Resolved, That this House of Delegates call public attention to this disproportionate condition and instruct the Council of the California Medical Association to advocate if necessary the state and local governments conduct these programs themselves without federal assistance.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

Resolution No. 15

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, It has been the custom for various medical schools within this state to solicit contributions from their alumni for new endowments and for maintenance and research expense; and

WHEREAS, One of the main obstacles in the way of receiving these funds has been the inertia of the individual donor; and

WHEREAS, It is imperative that the alumni of medical schools at this time in order to prevent the infiltration of federal money and federal domination, or state money and state domination, to assist in every way possible, particularly financially, the privately endowed medical colleges; now, therefore, be it

Resolved, That the House of Delegates establish the custom that members of the California Medical Association must remit with their yearly dues to their county medical society a receipt from a medical school in California acknowledging a donation to the medical school without specifying the amount, except that it be in excess of $10. Should the individual members not wish to make a specific donation to any one California medical school they shall add at least $10 to their dues, this $10 to be contributed to a fund established by the California Medical Association for assistance of medical education.

VICE-SPEAKER CHARNOCK: This will go to Reference Committee No. 3.

Resolution No. 16

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, Advances in medical knowledge in recent years have extended to the point where the costs of research and education have mounted at an alarming rate; and

WHEREAS, The costs of operation and maintenance in the various medical schools have similarly increased; and

WHEREAS, The income derived from endowment, investments and contributions to medical schools has diminished as a result of these increased costs; and

WHEREAS, The general public is being bombarded with information advocating federal subsidy of medical education; and

WHEREAS, In desperation many of our leading medical schools may be forced to accept this federal aid and thereby dance to the tune the piper plays; and

WHEREAS, All practicing physicians and members of the California Medical Association are vitally interested not only in the prevention of medical subsidy and governmental domination of medical education but also in the furtherance of free, private enterprise in medical education; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association establish a fund, the moneys of which shall be kept separate and without profit to the California Medical Association, for the purpose of collecting contributions which in turn shall be used by the Council for contributions to

medical schools within this state and/or to similar funds established by the American Medical Association; and, be it further

Resolved, That California Medical Association encourage by this resolution and by publicity thereupon and by active solicitation contributions from practicing physicians and donations made through the estate of physicians who have benefited by the presence of these medical schools; and, be it further

Resolved, That any layman or lay organization who wishes to contribute to this fund be encouraged to do so to the fullest extent.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

Resolution No. 17

DR. BURT L. DAVIS (Santa Clara County):

WHEREAS, It would be mutually advantageous for medical profession and medical students to have the opportunity to interchange ideas and opinions; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association desire that arrangements be made to send a copy of CALIFORNIA MEDICINE to each registered student in the state of California.

VICE-SPEAKER CHARNOCK: This will be referred to both Reference Committee No. 2 and Reference Committee No. 3. Both committees will act upon this resolution.

Resolution No. 18

DR. LEON PARKER (San Francisco County):

Be It Resolved, That the House of Delegates of the California Medical Association instruct the Council of the California Medical Association to set up a Board of Approval of voluntary health insurance; and, be it further

Resolved, That the Council of the California Medical Association shall elect five (5) of its own members to be the directors of such a board, and that such board shall be furnished with the necessary executive, clerical, and statistical force to operate; and, be it further

Resolved, That the classes of voluntary health insurance shall be A, B, and C; and, be it further

Resolved, That Class A shall consist of those forms of health insurance, or policies that permit free choice of physician, and are able to furnish service or indemnity according to a schedule that will fulfill its aims and claims; and, be it further

Resolved, That Class B shall be those forms of health insurance, or policies, or plans that do not give free choice of physicians, but that do fulfill other tenets in Class A; and, be it further

Resolved, That Class C shall be those forms of insurance, or policies, or plans, that neither give free choice of physician or fulfill the other tenets set forth in Classes A and B; and, be it further

Resolved, That any insurer who wishes to be classified must apply for his approval, furnish all necessary information and agree that approval may be withdrawn if it is shown that he has misrepresented himself in his application or makes changes during the time of approval that make the facts contrary to what they were at the time of approval.

VICE-SPEAKER CHARNOCK: This is referred to Reference Committee No. 3.

Resolution No. 19

DR. WILBUR BAILEY (Los Angeles County): This resolution has the interest of the Board of Medical Examiners and our own Legislative Department.

RESOLUTION REGARDING REGISTRATION OF PSYCHOLOGISTS

WHEREAS, Properly trained psychologists with high ethical standards who work under the guidance of doctors of medicine render a genuine public service; but

WHEREAS, There are a host of other individuals partly or completely untrained who pose as psychologists; and

WHEREAS, State licensing might seem a ready answer to stopping these "mind meddlers" whose talents range from bunco to blackmail, such licensing has two big disadvantages: (1) Nearly anyone who has worked as a so-called psychologist for three years would be "blanketed in" under "grandfather" clauses in some of the bills which are proposed; (2) licensing boards and licensing laws after passing through the process of legislative amendments and revisions frequently turn out very differently than expected; and

WHEREAS, Numerous conferences between members of the Board of Medical Examiners and various groups of university-trained psychologists reveal that these ethical psychologists wish to work under the guidance of properly licensed physicians and surgeons; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association instruct its Council to consider the problem of giving such psychologists appropriate recognition and registration in the California Medical Association and its branches; and, be it further

Resolved, That a plan of registration under the Board of Medical Examiners, such, perhaps, as the properly trained physiotherapists are presently proposing in bills before the Legislature, be considered as being appropriate for the psychologists; and, be it further

Resolved, That the House of Delegates place itself firmly on record as being against the formation of an additional Board of Psychologists, or any plan of licensing under such a board.

VICE-SPEAKER CHARNOCK: That will be referred to Reference Committee No. 3.

Do we have any more resolutions to present to the House?

Constitutional Amendments

DR. E. T. REMMEN (Los Angeles County): Mr. Speaker, there are a few points in the new Constitu-

tion which some members of the committees who studied the constitutions for two years feel should be separately presented to the House of Delegates in order that they may be considered next year. They are very brief:

Be It Resolved, That Article III, Part A, Section 1 of the Constitution be amended to read as follows:

The House of Delegates shall consist of

(a) Delegates elected by the members of component societies as provided in the By-Laws;

(b) Officers of the Association as designated in Article VI, Section 1 of this Constitution. Excepting the Secretary-Treasurer and the Editor, they shall have the right to vote.

Anything in the Constitution and By-Laws which is in conflict with the foregoing is hereby repealed.

That is separating the Council from the House of Delegates.

VICE-SPEAKER CHARNOCK: This amendment to the Constitution will be placed upon the table.

DR. E. T. REMMEN: The second amendment:

Be It Resolved, That Article III, Part B, Section 9 of the Constitution be amended to read as follows:

(a) District Councilors shall be elected by vote of the delegates from each district in the manner and at the time specified in the By-Laws.

Paragraph (b) is hereby repealed, except that the present Councilors-at-large shall complete their terms.

Anything in the Constitution and By-Laws in conflict with the foregoing is hereby repealed.

Thereby abolishing the office of Councilor-at-large.

VICE-SPEAKER CHARNOCK: This again will be laid upon the table.

DR. E. T. REMMEN: The third one:

Be It Resolved, That Article III, Part B, Section 9 of the Constitution shall be amended to read as follows:

The Council shall consist of:

(a) Eleven District Councilors elected from the Councilor districts specified in this Constitution.

(b) The President, President-Elect and Speaker. In addition the Secretary-Treasurer and Editor, but without the right to vote.

Anything in the Constitution and By-Laws which is in conflict with the foregoing is hereby repealed.

Again removing the Councilor-at-large.

VICE-SPEAKER CHARNOCK: Again this is an amendment to the Constitution. It will lie on the table.

DR. E. T. REMMEN: The fourth one is merely an addition to Article IV, Section 5 of the Constitution of one clause.

Be It Resolved, That Article IV, Section 5 of the Constitution be amended to read as follows:

"At each regular session of the House of Delegates the Council shall submit to it an itemized budget stating the proposed expenditures of the Association for the ensuing year. The budget may be altered or revised by the House of Delegates, but must be adopted by the House before adjournment of the session. After its adoption no expenditures in excess of the amount of the budget item covering the subject of such expenditures may be made in the year covered by the budget by the Association or any of its officers, agents or employees unless the Council by a three-fourths vote of all voting members shall first approve such excess expenditure by resolution duly adopted, and further provided that in no instance may the Council expend funds in any fiscal year in excess of 25 per cent more than the total amount of the budget without permission of the House of Delegates. Recurring items in the budget (fixed expenditures covering more than one year) shall, when first adopted, be binding as to the subsequent budgets to the extent of commitments or obligations entered into by the Association within authority granted by the House of Delegates or this Constitution or the By-Laws.

Merely a remote safeguard on funds, looking forward to a Constitution that may last for 50 years.

A MEMBER: Mr. Speaker, a point of order.

VICE-SPEAKER CHARNOCK: What is it?

SAME MEMBER: Is this a discussion or resolution?

VICE-SPEAKER CHARNOCK: The resolution has been read as such. It was read in brief and the chair rules this is to be laid on the table.

Now, do we have any more resolutions or amendments?

Resolution No. 20

DR. L. C. BURWELL (Los Angeles County): Mr. Speaker, members of the House of Delegates: This resolution originated in the general practice section of the Los Angeles County Medical Association. I brought this resolution to the Los Angeles County Medical Association and it was passed at the last meeting. Therefore, I am passing it on from them to you.

WHEREAS, The Department of Social Welfare of the State of California is a well organized functioning department in our state government; and

WHEREAS, This department establishes standards and makes minimum regulations which must be met by all adopting agencies; and

WHEREAS, The Department in its adoption manual has stated that children in adopted homes during their probationary time should be under the care of a qualified physician, "preferably a pediatrician"; and

WHEREAS, Some adoption agencies in the State of California have required the prospective foster parents to call on a pediatrician to care for the child during that probationary time; and

WHEREAS, In so doing the agencies are not only exceeding the requirements laid down by the State Department of Social Welfare but are discriminating against physicians in general practice and, as a result, deny to the adoptive parents the right of free choice of physician; now, therefore, be it

Resolved, (1) That this House of Delegates of the California Medical Association instruct the Council to ask the Department of Social Welfare of the State of California to delete from its manual the phrase, "preferably a pediatrician," and (2) that the Department of Social Welfare be requested to advise all adoption agencies in the State of California of such deletion from their manual; and to recommend to the agencies that any doctor licensed to practice medicine by the State of California be privileged to care for said children.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3.

Now, do we have any more resolutions to present? This is your last opportunity to present resolutions and amendments. We will now have a motion to adjourn for the adjourned meeting tomorrow at 3:00 o'clock at the Edison Building.

. . . It was moved, seconded, and carried that the meeting be adjourned at 5:00 o'clock p.m. . . .

MONDAY AFTERNOON SESSION
MAY 14, 1951

The Monday Afternoon Session was held in the Auditorium of the Southern California Edison Building, and was called to order at 3:00 p.m. by Vice-Speaker Donald Charnock, who presided.

VICE-SPEAKER CHARNOCK: Will the House of Delegates please be in order.

Will Dr. Morrison please come forward.

DR. A. A. MORRISON (Ventura County): Mr. Speaker, there are now 144 delegates seated. This constitutes a quorum under the new Constitution.

We also passed out cards and had you bring them in. If any of those cards were not signed, will you please sign them and pass them over to one of the aisles so that we can pick them up?

VICE-SPEAKER CHARNOCK: The first order of business is the roll call.

. . . Roll call. . . .

VICE-SPEAKER CHARNOCK: We declare that the House is now in good order.

The first order of business is a report by Dr. Lyle Craig, Chairman of Reference Committee No. 3. Dr. Craig!

DR. LYLE CRAIG: This adjourned session of the House of Delegates is for the express purpose of voting on the By-Laws and receiving amendments thereto. The By-Laws which are to be voted on are those as published in the Annual Reports Bulletin, of which some of you may yet have a copy, plus the changes which were introduced yesterday by Reference Committee No. 3, and we are presently laying on the table, plus the changes which were added to the Report of the Committee by your action of yesterday, which changes are also lying on the table and have been incorporated as a part of these By-Laws by your action.

The first of these changes, as you will note on the slips handed you today, is concerned with Chapter V, Section 2.

"Commencing with the 1952 regular session of the House of Delegates each component society shall be entitled to one delegate for each fifty (50) active members or major fraction thereof, according to its membership as of the first day of November of the preceding year; provided, however, that each component society shall be entitled to a minimum of two delegates."

Chapter VII, Section 1, page 44:

"Insert after the line '(1) Physicians' Benevolence Committee' the new line '(m) Military Affairs and Civil Defense.' "

The ensuing line being renumbered "n" instead of the present "m."

Also to insert in Chapter VII a new section to read:

"Section 20—Committee on Military Affairs and Civil Defense.

"The Committee on Military Affairs and Civil Defense shall have the duty and responsibility to consult with constituted authorities concerning these subjects and administer problems of civil defense and of a military nature for the California Medical Association."

The ensuing sections of Chapter VII have been renumbered Section 21 and Section 22 respectively.

This, then, is the document upon which we are asked to vote.

Mr. Speaker, I move the adoption of the By-Laws as presented to the House.

VICE-SPEAKER CHARNOCK: Thank you, Dr. Craig.

At this time there will be an opportunity for any member of the House of Delegates to debate this set of By-Laws.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: Does anybody want to debate these?

. . . The question was called for. . . .

VICE-SPEAKER CHARNOCK: Nobody wants to debate it. That is fine.

DR. FRANCIS T. HODGES (San Francisco County): Mr. Speaker, a point of order.

VICE-SPEAKER CHARNOCK: What is your point of order?

DR. FRANCIS T. HODGES (San Francisco County): Is this the proper time for amendments to these?

VICE-SPEAKER CHARNOCK: No, sir. If you please, we will announce that in just a moment. At this time the order of business will be a vote upon this existing instrument. Later on there will be an opportunity of putting forth amendments to the By-Laws.

At the present time the order of business is to vote upon this instrument as has been presented by Dr. Craig. How do you wish to vote?

. . . There were calls of acclamation. . . .

VICE-SPEAKER CHARNOCK: Will somebody make a motion to that effect?

. . . It was moved, seconded and carried that the vote be by acclamation. . . .

VICE-SPEAKER CHARNOCK: We will then vote by acclamation. The vote is now upon the By-Laws as proposed by Dr. Craig. All those who are in favor of these By-Laws will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: They are passed and so recorded.

At this time there is an opportunity to present amendments to the Constitution and the By-Laws. As there is no advantage in presenting amendments to the Constitution at this time, the chair will rule that they will be put over until tomorrow.

It is now the time when you may present amendments to this present existing new By-Laws.

DR. A. G. MILLER (San Mateo County): Without reading any "whereases" on the matter, it pertains to the portion of the By-Laws under letter "K" that Dr. Craig just read to you. The resolved portion in this particular Section 2 of Chapter V, that in the phrase "major fraction thereof" the word "major" be struck out and the word "any" be substituted.

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3 and will be reported back tomorrow.

DR. A. A. KIRCHNER (Los Angeles County): Mr. Chairman, if you will turn to your Bulletin, page 41, the right lower column which has to do with the provisions requiring two House of Delegates meetings per year, this is an amendment correcting that.

Resolved, That the By-Laws of this Association, the California Medical Association, adopted on May 14, 1951, be and the same are hereby amended as follows:

(1) Section 7 of Chapter V is hereby amended to read:

"Section 7—Sessions and Meetings

"(a) In each year there shall be a regular session of the House of Delegates (herein at times called the Annual Session); the time and place of such regular session to be determined by the Council as far as possible in advance and notice thereof published in the journal of the Association.

"(b) In addition to regular sessions, special meetings of the House of Delegates may be called at any regular or special meeting of the Council, by a two-thirds vote of all the members of the Council, or by written call stating the object of the meeting, filed with the Secretary in the office of the Association and signed by one-half or more of the members of the House of Delegates. Upon the filing of such call with the Secretary, the Council shall within 30 days thereafter fix the time and place for the holding of such special meeting and cause written notice thereof stating the object of the meeting to be sent by United States mail, postage fully prepaid, to each member of the House of Delegates, addressed to him at his office or place of residence, as shown by the records of the Secretary's office, at least 15 days prior to the date of such meeting."

Now, on page 42, I refer you to Section 9. In order to streamline the By-Law to fit with this resolution Section 9 of Chapter V is amended to read:

"Section 9—Membership of Credentials and Reference Committee.

"Each of the aforesaid committees shall consist of three members, the chairman of each to be designated by the Speaker.

"The Speaker, the House concurring, shall refer said reports, resolutions, and business to the respective Reference Committees, but may allocate among them any of said reports, resolutions or portions thereof, and other business, to avoid duplication and to expedite the business of the House of Delegates.

"Each Reference Committee shall prepare a written report dealing with and making recommendations on all matters submitted to it. The report of each committee may be acted upon as a whole or section by section, as the House may determine."

VICE-SPEAKER CHARNOCK: Thank you, Dr. Kirchner. These will be referred to Reference Committee No. 3 for action tomorrow.

Dr. de los Reyes!

DR. J. M. DE LOS REYES (Los Angeles County): Mr. Speaker:

Resolved, That the By-Laws of this Association, California Medical Association, adopted May 14, 1951, are hereby amended as follows:

(1) Add to Chapter V a new Section 12 reading as follows:

"Section 12—Loyalty.

"The Committee on Credentials shall require each delegate and alternate who desires to be seated as a member of the House of Delegates to subscribe to the oath or affirmation in the form required for officers under Section 3 of Chapter XIII. In the event of refusal to subscribe to such oath, the Credentials Committee may at its discretion refuse to include such person in its written report to the House of Delegates designating the delegates and alternates entitled to membership therein. Any person refused a seat by action of the Credentials Committee shall have the right to appeal to the House and by majority vote the House may overrule the Credentials Committee and seat such person as a delegate."

(2) Add to Chapter XIII a new Section 3 reading as follows:

"Section 3—Oath of Office.

"All officers and employees of the Association, upon election or appointment, shall subscribe to an oath or affirmation as follows:

" 'I do not belong and have not belonged to any organization advocating the overthrow or change of the form of government of the U. S. A. by violent or unlawful means, nor do I belong or have belonged to any organization while it was listed, published or held to be subversive by the Department of Justice of the United States of America.' If, after full hearing, the Council shall find that an officer or employee falsely subscribed to the oath or affirmation,

it may in its discretion remove the officer or employee from his office or position and fill the vacancy so created."

VICE-SPEAKER CHARNOCK: This will be referred to Reference Committee No. 3 for action.

DR. JOHN W. GREEN: Mr. Speaker, members of the House: Representing the Council in a duty which has to be performed annually, we have already run into a little bit of difficulty with your new set of By-Laws in selecting names to present to the House for the various standing committees. We find that in at least one instance the chairman of the committee who has served us faithfully through many years, to wit, Dr. Murray, would not like to see this read as it is now written, because it would require him to throw off of his committee one of his most trusted lieutenants and put an untrusted Councilor in his place. (Laughter.)

So, in that connection I would like to offer this change in the By-Laws, Chapter VII, Section 2:

This resolution is to amend Chapter VII, Section 2 of the By-Laws, as printed on page 44 of the Annual Reports Bulletin.

WHEREAS, It would appear inappropriate that a member of the Council always be a member of a standing committee; now, therefore, be it

Resolved, That the word "shall" in line three of the first sentence be changed to "may" and the first sentence shall thereafter read as follows:

"Unless otherwise provided in these By-Laws, each of the standing committees (except House of Delegates Reference Committees) may consist of one member of the Council and two other members."

VICE-SPEAKER CHARNOCK: Thank you, Dr. Green.

Do you have any more changes in these By-Laws? Dr. Parker!

DR. LEON PARKER (San Francisco County):

Be It Resolved, That Chapter V, new Section 12, shall read:

"All officers, delegates and alternates shall take the following oath of allegiance:

"'I pledge allegiance to the flag of the United States of America,
And to the Republic for which it stands,
One nation indivisible,
With liberty and justice for all.'"

VICE-SPEAKER CHARNOCK: Thank you, Dr. Parker. That will be referred to Reference Committee No. 3.

Does anybody else have amendments? There are no more, I guess.

At this time the Speaker is instructed to have the delegates gather around their various district placards for the purpose of electing District Councilors. If you will refer to Section 6, Chapter VIII of the new By-Laws on page 47 of the Annual Reports Bulletin, "At least twenty-four hours prior to the second meeting at each annual session of the House of Delegates the delegates from those districts in which Councilor vacancies are about to occur shall separately meet, and in each district the delegates shall elect a chairman and a secretary. At such caucus the delegates in each district shall by nomination, secret ballot and majority vote of the delegates present elect a District Councilor from such district to serve for the ensuing term."

For your convenience, as this is the first time this has been done under this new set of By-Laws, we have arranged these placards where you can get together.

A motion to adjourn is now in order, and then you can select your District Councilors.

. . . It was moved, seconded and carried that the meeting be adjourned at 4:00 o'clock p.m.

TUESDAY AFTERNOON SESSION
MAY 15, 1951

The Tuesday Afternoon Session was held in the Music Room of the Biltmore Hotel, and was called to order at 1:00 p.m. by Speaker Lewis A. Alesen, who presided.

SPEAKER ALESEN: Will the House of Delegates please come to order.

Dr. Morrison!

DR. A. A. MORRISON: Mr. Speaker, we now have 147 delegates seated. This constitutes a quorum under the new Constitution.

SPEAKER ALESEN: Mr. Secretary, shall we proceed with the roll call?

. . . Roll call. . . .

SPEAKER ALESEN: At this time, as you know, we are about to hear the inaugural address of our incoming President, Dr. H. Gordon MacLean. The firm of Whitaker and Baxter has taken care of our radio talks in the past. They took care of Dr. Henderson's address last year. The gentleman responsible for the success of that broadcast is with us to take charge of our broadcast today. He is one of the members of the firm of Whitaker and Baxter, Mr. Ned Burman, who will instruct us as to how to proceed. Mr. Burman!

MR. NED BURMAN: Thank you, Mr. Speaker.

Members of the House, we are here to put on a very special events broadcast. We consider this a great honor and also we believe it is a fine idea for the California Medical Association to bring its story to the people of California, and this we consider a very dramatic special event which we want to bring to the people.

What we want to do at this time is to have you regard yourselves as though you were sitting in one of the main studios in NBC or CBS, while we put on a nationwide broadcast. Of course, this isn't "Double or Nothing," so we aren't going to expect any antics of any kind.

What we want you to do is maintain absolute quiet for about 30 seconds before we go on the air, and on the given applause cues, if you will come through and make it sound like the rooting section at the Coliseum during a USC-Notre Dame game, that would help stimulate audience interest, I am sure.

Just to review our cues, for 10 seconds preceding the opening words on the broadcast, we would like to come in with applause from the audience. So the applause cue will be this signal (indicating). Then, when we want you to fade down for the voices to come in, we will give you this signal (indicating), and then if you will hold any crowd noises during Dr. MacLean's speech to a minimum, it would be appreciated.

During the course of the speech should you feel like applauding, please feel free to do so. However, if you applaud for too long, it might tend to slow up our timing, so I will give you this fade signal again to cut off the applause so the timing won't be affected.

In one minute we will go on the air. (Applause.)

MR. NED BURMAN: Good evening, ladies and gentlemen. We greet you from the Biltmore Hotel in Los Angeles, where the physician members of California Medical Association are gathered for its 80th Annual Session.

The miraculous advances in modern medicine which have been recorded during the past 100 years of medical progress have been spurred by scientific meetings sponsored by organized medicine. Great strides have been made in the past year in the diagnosis and treatment of human ills. And distinguished physicians from all over the country are here to participate in the scientific sections. This special broadcast is coming to you from a meeting of the House of Delegates, which might be described as the nerve center of the medical profession in California. Doctors from every corner of this great state are here to conduct the business of their organization and to participate in the installation of incoming officers. Now, the Speaker of the House of Delegates, Dr. Lewis A. Alesen of Los Angeles, will introduce the new President of the California Medical Association. Dr. Alesen!

SPEAKER ALESEN: Members of the House of Delegates and ladies and gentlemen of the radio audience: It is now my honor and privilege to introduce to you the new President of the California Medical Association, Dr. H. Gordon MacLean of Oakland. Dr. MacLean! (Applause.)

DR. H. GORDON MACLEAN: Mr. Speaker, members of the House of Delegates of the California Medical Association, ladies and gentlemen: It is with a great feeling of honor that I accept the presidency of the California Medical Association.

The medical profession in California has had many grave problems to face, many great challenges to meet, in recent years. Leaders of the profession, to their everlasting credit, have faced those problems and met those challenges squarely and unequivocally. Their example has been inspiring, and the responsibility to follow that example I feel very deeply.

Most of the activities and projects of the California Medical Association are of a serious and earnest nature. Occasionally, however, a lighter note creeps in.

Many in this audience must have been amused recently to read of a new and sensational method of treating such serious diseases as appendicitis, polio, cancer and stomach ulcer by using colored goggles and manipulating tender spots on the soles of the patient's feet.

This revolutionary "technique"—I use the word in quotes—was described in detail before an Assembly Committee in Sacramento. Students were charged $200 for a two-day instruction course, where many closely guarded secrets, such as the chemical formula of salt and water, were divulged!

Through its own investigation department the California Medical Association learned of the fabulous mysteries of this technique and related them, along with other recent examples of quackery, to the Assembly Committee, with the result that action has been taken in Sacramento to strengthen the protection afforded California citizens against unscrupulous fakers who prey on the gullible, the ignorant, and the unthinking.

That, you might say, is an example of "preventive medicine" of a political nature. You've heard a lot in the last few years of doctors in the role of politicians. I know of few doctors who ever wanted to go into politics, but doctors have had to take an active interest in politics because as doctors they are vitally concerned with all measures that threaten a deterioration of medical care, whether those of ambitious government bureaus or those of individual promoters who capitalize on the sickness, misfortune and misery of others.

Because the practice of medicine, if it is to be performed faithfully and effectively, is essentially a personal service, the personal physician-patient relationship is a most important ingredient in medical care. The modern personal physician — in just the same way as the old-fashioned family doctor of the horse-and-buggy days—takes care of the whole man. The impersonal doctor could just as well be an employee of the government, and in those countries where doctors have become civil servants, impersonal and inferior medical care for all the people has resulted.

Organized medicine has had to think politically because even here in America there are those to whom the quality of medical care is far less important than the bureaucratic power to be gained through schemes of compulsory health insurance and the socialization of medicine.

And even though the voluntary health insurance system is growing at a phenomenal rate — even though 20 million additional people have enrolled in Blue Cross, Blue Shield and indemnity insurance plans in the past two years—and in spite of the fact that thousands of responsible public organizations have spoken out clearly against state medicine, the socializers haven't given up yet. The Federal Security Administration, whose chief, Mr. Oscar Ewing, likes to be known as "Mr. Socialized Medicine Himself," is still spending your tax dollars, ladies and gentlemen, to lobby for compulsory health insurance, and

is demanding once again that the Congress embrace that foreign system and adopt it as the law of the land.

The California Medical Association is proud of the hard, unceasing work doctors have done in the interests both of the public and the profession in the field of preventive legislation.

Necessary as that work has been, however, it is, by its very nature, largely a defensive undertaking. I think it is timely on this occasion to review briefly some of the positive accomplishments of organized medicine — the everyday, grass-roots, undramatic advances in personal physician-patient relations that have been achieved locally by doctors working cooperatively through their county medical societies.

For example, there is the matter of night and emergency call plans.

Because it's human nature to put off, many people, when they move to a new community or neighborhood, don't get around to looking up a doctor until the middle of some pain-wracked night.

Because that has happened so often, medical societies throughout the country have formulated emergency call systems to guarantee that anyone, resident or traveler, can obtain the services of a doctor at any hour, day or night or holiday, 365 days a year!

Every effort is made to publicize the existence of these emergency call plans. In Santa Clara County, for example, doctors ran a series of newspaper ads to inform the public of the service. And in most counties the medical societies advertise the service in the classified section of the telephone directories.

Another development of great importance to the public, and which more and more medical societies are adopting, was pioneered by Los Angeles doctors more than 25 years ago. That is the establishment of so-called arbitration or professional relations committees.

These committees function to consider complaints of patients. Such complaints are given thorough, confidential consideration, and if the physician is found at fault, he is so informed and suggestions are made to him regarding corrective steps.

Many complaints are based on misunderstanding. People are often surprised, for instance, when it is pointed out to them that the fee paid to a doctor isn't net compensation for his personal services, that he has a payroll and overhead to meet just as a business man. People are sometimes surprised to learn, too, that in the case of serious illness, the doctor's fee represents only about one-quarter of the patient's expense, the balance being accounted for by medicine, nurses, hospital care and other services.

One large California county society reports that only one or two bona fide serious complaints are received per month. Its arbitration committee, once the case has been decided, vigorously defends the injured party, regardless of whether it is the doctor or the patient! In a recent case in which the doctor ignored the committee's recommendations to reduce an excessive fee, the county medical society provided legal counsel for the patient, and the arbitration committee chairman testified against the doctor on the patient's behalf!

Three years ago the Alameda County Medical Association earned national attention with a series of newspaper advertisements calling public attention to the fact that in America medical care is available for all, regardless of ability to pay. Daily, the association pointed out, doctors of each community treat hundreds of persons at fees scaled down to meet the patient's circumstances. Daily members of the medical profession treat the needy in hospitals and clinics without charge. The Alameda Society guarantees medical care, without payment if necessary, to everyone in the county.

Some county societies maintain Bureaus of Medical Economics which serve to assist patients in financial problems relating to medical care. One society maintains a social service department headed by an expert medical social service consultant.

Again, California doctors pioneered in the development of physician-sponsored medical care plans. California Physicians' Service, sponsored by the California Medical Association, was the first statewide service type voluntary health insurance plan in the nation, and has served as a model for other physician - sponsored plans throughout America. Let's be realistic; C.P.S. is far from perfect. It doesn't yet function to the 100 per cent satisfaction either of subscriber or doctor. But the service is continually being studied and improved in the recognition of the many problems that constantly arise as, for example, the financial problems posed by the devaluation of both the patient's and the doctor's dollar. Patients, while interested in premium cost, are primarily concerned with adequate benefits and good medicine. And from the standpoint of both patient and doctor, adequate doctors' fees are important, for it costs money to render good medical practice.

The activities of county medical societies cover a multiplicity of fields, and vary according to community needs: An important activity, for example, of the San Diego County Medical Society was its participation in a mass chest x-ray survey in cooperation with the U. S. Public Health Department. In Fresno County members of the County Medical Society concerned with the health aspects of the migratory labor problem have formed a voluntary panel to give medical attention to children whose families are economically unable to engage a private physician and who are ineligible for county hospital care.

One particularly important activity—a California-pioneered idea and an example of how organized medicine works in the community interest—is the establishment of regional non-profit medically-sponsored community blood banks. Nine such community ventures geared to meet the complete requirements for blood transfusions in the regions they serve are functioning in San Francisco, in Oakland, in Eureka, in Sacramento, in San Diego, in San Mateo, in Santa Rosa, in Fresno and in Santa Barbara. Several of these banks were made possible by

loans of money by the California Medical Association toward their establishment.

The Irwin Memorial Blood Bank, sponsored by the San Francisco County Medical Society, was the first in this chain of humanitarian undertakings. Since its founding 10 years ago it not only has taken care of the blood transfusion needs of San Francisco and adjoining areas, but has supplied whole blood and plasma to the Armed Services during the war and is again, in conjunction with the Red Cross, serving as a procurement and distribution center for transfusion needs of the wounded in Korea.

That need, as we all know, is very great, and the doctors of California can well take pride in the farsightedness and the unselfish sacrifice of time and effort on the part of those in their ranks who have labored so hard to make possible the dramatic saving of the lives of our men in foreign battlefields. I hope that all of you listening now who are able to give blood will make an appointment at once with your nearest blood bank to go and give a pint.

Organized medicine, I think, can be forgiven if it points with pride to its successful efforts on behalf of the public and in the interest of a free profession in vigilantly combating quackery, whether on the part of unqualified practitioners in the field of diagnosis and treatment or on the part of unscrupulous schemers in the field of politics.

The medical profession in America can be proud, too, of the great strides that have been made in the betterment of the nation's health; of the dramatic increase during the past half century of 19 years in life expectancy; of the great reduction in both maternal and infant mortality rates; of the virtual elimination of such formerly dread diseases as typhoid fever and smallpox; of the spectacular advances in the prevention, control and treatment of many other ills.

Doctors and the public alike can be gratified over that record of continuing medical scientific progress. I believe there is a source of common gratification, too, to be found in the less dramatic but nonetheless very real progress being made every day in doctors' offices throughout California and the nation toward a better relationship, a better understanding between doctor and patient.

No one knows better than the medical profession how vitally important that understanding is.

The free practice of medicine has been under political attack. Doctors have risen vigorously to meet those attacks. We have fought hard—and successfully so far—but we recognize in all humility that the greatest factor in that success has been the wonderful understanding and support on the part of the public.

Early in the fight we learned that the great majority of the American people—not just doctors—still believe in the American way of life!

On behalf of the doctors of California I wish to thank with deep sincerity the people of California for their ready understanding and splendid support, and I pledge unceasing devotion by the California Medical Association to the goal of providing the people of California the finest medical care at a price they can afford to pay.

I thank you. (Applause.)

MR. NED BURMAN: Ladies and gentlemen, this has been a special broadcast from the 80th Annual Meeting of the California Medical Association. Those heard on the program were the Speaker of the House of Delegates, Dr. Lewis A. Alesen of Los Angeles, and the new President of the California Medical Association, Dr. H. Gordon MacLean of Oakland.

This is Ned Burman speaking for the California Medical Association convening in the Music Room of the Biltmore Hotel in Los Angeles. (Applause.)

SPEAKER ALESEN: We are indebted to Dr. George H. Kress, for many years Secretary-Treasurer of the California Medical Association, one of its Past Presidents, and now its official Historian, for a list of the living Past Presidents of this Association. You know, in adopting the Constitution you made the Past Presidents ex-officio members of this House.

I am going to read the names of these men, many of whom I understand are present here today, and ask them to stand. Please withhold your applause until all have been named.

Presidential

Year	*Name*	*City*
1916	George H. Kress	Los Angeles
1925	Edward N. Ewer	Oakland
1928	William H. Kiger	Los Angeles
1930	Lyell C. Kinney	San Diego
1931	Junius B. Harris	Sacramento
1933	George G. Reinle	Oakland
1935	Robert A. Peers	Colfax
1940	Harry H. Wilson	Los Angeles
1942	William R. Molony, Sr.	Los Angeles
1943	Karl L. Schaupp	San Francisco
1944	Lowell S. Goin	Los Angeles
1946	Sam J. McClendon	San Diego
1947	John W. Cline	San Francisco
1948	E. Vincent Askey	Los Angeles
1949	R. Stanley Kneeshaw	San Jose

(Applause.)

SPEAKER ALESEN: We have heard one new President speak, ladies and gentlemen. It is now a distinct pleasure to present to you one of the men of the California Medical Association, a Past President of this Association, a man who spent a lot of good, hard work in our behalf, and a man to whom, of course, I cannot pay a higher tribute than to say he is one of our own—Dr. John W. Cline, Past President, and the new incoming President of the American Medical Association. Dr. Cline! (Standing applause.)

DR. JOHN W. CLINE: Thank you very much. Mr. Speaker, gentlemen: It is a great pleasure for me to appear again in this House, of which I was a longtime member in one capacity or another. I have been asked to say something concerning the various problems which confront American medicine at this time. I realize that you have a tremendous amount

of work ahead of you and the time, therefore, is limited. I shall sketch briefly some and devote considerably more time to a few.

I am sure you all are interested in the problem of medical education. Our medical schools, or many of them, are in serious financial distress. We recognize the hazards involved in any variety of federal subsidy for continuing operation of medical schools. The attitude of the American Medical Association is that subsidies should not be made for ordinary operation, but one-time grants for remodeling and construction would not possess the hazard of federal control. Otherwise the funds should be raised from private sources.

Recognizing that fact, the American Medical Association at its meeting last December gave a half million dollars, not as a matter of supplying the entire need, because obviously it would not do so, but to stimulate others to do likewise and to gain by that means sufficient funds to relieve the situation.

You of the California Medical Association showed your perception and your remarkable generosity in contributing $100,000. That is the largest contribution aside from that of the American Medical Association, and on behalf of the American Medical Association I sincerely thank you for having made it.

At that time it was necessary for the American Medical Association to establish a foundation to receive the funds coming from various sources. The National Fund for Medical Education headed by Mr. Herbert Hoover had not yet been announced, and premature mention of it at that time would have created an embarrassing situation.

This week the foundation established by the American Medical Association and the National Fund for Medical Education will be merged, and there will no longer be a division. Shortly every doctor in the country will be solicited to contribute to medical education, and it is sincerely hoped that all will respond promptly and generously.

Another item that has caused some concern, even at this meeting, has been a program of hospital standardization. It is finally taking shape. I think many of you know the general outlines, and I wish to assure those who have some worries that the American Medical Association will not forget the fact that general practice is a tremendously important part of medicine. (Applause.) In the representation from the American Medical Association, general practice will be adequately recognized.

I would like to speak extensively concerning public relations, but that would take too long a period of time. Many of our California county societies, and certainly the California Medical Association, are more familiar with the problems of public relations and more active in that field than are most of the corresponding societies throughout the country.

I would like to speak for a moment concerning press relations. It has been my experience in various capacities over the years dealing with men of the press, the reporters, editors and publishers, to realize they are extremely fine individuals. They are honest; they are making a real effort to to present to their readers a word-picture which is accurate. When misunderstandings between us and the press have arisen, more of the fault has been on our side than theirs. If we cooperate adequately with the press we will permit them to fulfill their function much better, and it will result in better press for us.

Now, concerning the American Medical Association: Its policies, of course, are made just as yours are made, by the House of Delegates, and carried out by the officers. Throughout the country they are sometimes misunderstood. The officers and the members of the House of Delegates of the American Medical Association are desirous of having the constructive suggestions which any of you may make.

On the other hand, there has been and I suppose there always will be, just as there has been from time to time in this state, destructive criticism. While we welcome and will receive and consider constructive criticism, we must ignore that type which is purely carping. It has been my observation, in years in medical organizational work, that those who throw rocks toil not. If they wish to criticize they should put their shoulders to the wheel and try to do a job.

We have also been subjected to considerable criticism from outside the profession. This has resulted largely from misunderstanding and from lack of knowledge of what the American Medical Association is, and what it is trying to do. It, also, has been in part the result of a systematic campaign of abuse over the past 15 years.

On occasions this has sunk to the level of vilification, even to the level of libel, and has placed the American Medical Association in a very difficult situation. Its public relations were not good, and we reached a low ebb in 1948. In that year Mr. Truman ignored the party platform and campaigned on a personal platform, promising everything to everyone, including socialized medicine. It was generally assumed by him, by the socializers, and by many of the commentators and columnists, that his reelection was a mandate to enact socialized medicine.

Shortly following that election the House of Delegates of the American Medical Association met in St. Louis. It discussed this matter at considerable length. It issued a clear-cut, ringing statement of principles which was actually drawn up by the California delegation to that convention. The House directed a campaign be waged and levied a $25 assessment to implement the campaign.

The campaign was set up on the basis of the experience of the successful campaign in which many of you actively participated here in California in 1945. The three bases of that were: First, to convince the people of this country of the danger to their medical care which would result from any system of socialized medicine; second, to convince them of the fact that historically it had been the forerunner of socialism in general in most countries and, therefore, presented a hazard to all activities; and third, to develop and expand voluntary

health insurance, to provide methods of prepayment of the costs of medical care.

That was a very sound method of procedure.

In this state we had had more experience than had those elsewhere. Compulsory health insurance had been an issue here since 1918.

About 1920 it was voted down by the people of this state by a margin of two to one. Then came 1930 and the depression, and various studies were undertaken at that time to see what could be done to improve the distribution of the costs of medical care.

In 1938 the election of Mr. Olson precipitated the formation of C.P.S.

In 1939, when Mr. Olson made his proposals for socialized medicine, the legislators recognized the potential value of the program we were inaugurating, and in blueprint form C.P.S., even though it was not in operation, had tremendous moral value.

It grew slowly thereafter, and in 1945, we were confronted with a similar situation when Mr. Warren made his first proposal. He described C.P.S. as a miserable thing of about 100,000 members, and that was just about its size then.

Again the moral value of it was apparent. The demonstration of the intention of the medical profession of this state to try to solve the problems of the distribution of medical care carried tremendous weight.

Thereafter we inaugurated the campaign to expand voluntary health insurance in this state, not only C.P.S. but Blue Cross, and the insurance company plans.

In 1947 there was comparatively little difficulty in overcoming the proposal made for socialized medicine. There followed, as apparently there are developing at the present time, throughout the country, criticisms and questions about the advisability of the campaign.

I was your President, as Dr. Alesen said, in 1947-1948. I felt it incumbent upon me to ascertain from impartial sources whether the campaign we had waged had been as successful as we thought, or whether we had been deluding ourselves. I, therefore, asked Mr. Ben Read to give me the names of the Senators and Assemblymen and the legislative representatives in Sacramento who had been of most assistance in defeating the Warren proposal.

He gave me the names of eight legislators and nine legislative representatives. I wrote to all of them in questionnaire form. They all answered, except one of the legislative representatives.

Their answers took quite different forms. Some of them answered the questionnaire *ad seriatim*. Others wrote very brief paragraphs saying what they thought, and some of them took several pages to describe the effect that they felt our campaign and C.P.S. had had upon the outcome.

There was one striking thing: Every one of them was of the opinion that had we not had C.P.S., and had we not engaged in the intensive campaign for voluntary health insurance, socialized medicine would have been enacted.

In 1949 the full prestige and power of the Governor's office could drum up only a corporal's guard in one house of the Legislature to support his program. This year there is no serious proposal for socialized medicine. At the present time we have more than 65 per cent, or more than six and a half million people in this state covered by voluntary health insurance.

With those outlines, it was apparent that the American Medical Association should follow a similar pattern. Not only did we do that, but the same people directed the over-all strategy. Let us review the results of the campaign briefly.

Interest in health insurance has grown tremendously throughout the country. The knowledge of the people has grown tremendously. There has been a crystallization of public opinion. I think you can recognize by the character of current news stories the higher regard in which the American medical profession is now held due to the efforts it is making.

Over 90 per cent of the papers in this country are editorially opposed to socialized medicine. There are between ten and eleven thousand organizations of national, state and local scope on record with resolutions against it. The surveys have some importance. A labor survey recently showed that 45 per cent of labor were opposed to it. This is a continuing labor and management survey which is designed for the information of people who have an interest in such relationships, and I think it is a fairly accurate one. Forty-five per cent against, 28 per cent for, and 27 per cent had not made up their minds.

In Minnesota one of the newspapers keeps a continuing poll on various matters. In February 1949 it asked the question, "Is a national compulsory health insurance scheme needed?" The answers were "yes" 65 per cent, "no" 25 per cent. In February 1951, "yes" 37 per cent, "no" 53 per cent.

"Are you in favor of such a scheme?" February 1949, "yes" 56 per cent, "no" 23 per cent. In February 1951, "yes" 32 per cent, "no" 57 per cent.

You will observe in these figures that a considerable number of people have not made up their minds. This points up something I shall say later.

The growth of voluntary health insurance in this country has been tremendous. As a matter of fact, it has grown so rapidly that by the time the figures are compiled they are already out of date.

At the present time there are more than 20 million people covered by Blue Shield and other medically sponsored plans. There are more than 40 million people covered by Blue Cross plans; more than 72 million people have coverage of some type against the cost of illness.

A survey recently completed by the American Medical Association showed the following: That Blue Shield plans over the country paid 60 per cent of the cost of medical care for the people covered; that Blue Cross plans paid over 82 per cent of the cost for hospitalization of the people covered. This is real evidence of progress.

I would like to take just a moment to mention that

I recently was on a Joint Orientation Conference tour of the Department of Defense. I met a very interesting man, a man by the name of Roy Norr, on that trip. I heard he was a public relations man and I heard from people in New York he was one of the topnotch men in the country.

Subsequently I found out that this man represents Paramount Studios publicity, he represents Best Foods; he is the man who conducted the confectioners' campaign against the slogan, "Reach for a Lucky instead of a sweet." I think these establish him as a topnotch individual in his field.

At breakfast one morning he said he would like to speak to me and I agreed. He apparently did not want to say what he had to say in the presence of other people. As we left the dining room he said, "I want you to know that the campaign that you people have carried on and has been run for you by people whom I do not know, but whom I respect greatly, has been the most magnificent campaign of public relations which has been carried on in this country in the past 25 years."

From a man such as Mr. Norr, who never had anything to do with medicine and who did not know any of the people associated with the campaign, I think that is a compliment that we cannot overlook.

There have been criticisms of the campaign. There have been criticisms within our own ranks; criticisms that some of the methods used have not been quite the type of methods we would like to use. Of course they haven't. They are not the methods of the presentation of scientific papers. They are not in the language most of us are accustomed to use, but I found out recently how those pamphlets, the initial pamphlets, were constructed.

The Whitakers at that time resided at the Palmer House, and had a chambermaid who was a strong left-wing advocate of socialized medicine. They employed her to read over the pamphlets, after they were first drafted, to pick out the weak spots, to tell them what she didn't understand, and to show them how they could improve the pamphlets.

She took them home and passed them around among her friends, and came back with some very sound, solid criticisms. Whitaker and Baxter then felt that this was such a valuable contribution they did a similar thing with waiters, bellboys, elevator operators, with taxi drivers, and people of that type until they felt that they had a reasonably good cross-section of what approach would reach the minds of people in that particular educational bracket.

Then they went to insurance people, lawyers, bankers, and presented the same material to them, and these people found nothing objectionable in it.

So, when we begin to criticize some of the things that have been done, let us realize that this was very carefully done, very carefully worked out, and the results I have quoted to you, I think, prove the effectiveness of the campaign.

Just a word about elections. In elections in most states of large size, the influence of any segment of society can hardly be recognized. You all worked hard in certain elements of elections here. You didn't do it as county societies, or as a state association, or as the American Medical Association, but you worked as individuals and in informal groups.

There are some places in the country, however, where the influence of that type is easily recognizable. Senator Pepper, over the air, on *Reporters' Round-up* or *Meet the Press*, attributed his defeat in the primary to the activities of the medical profession and their wives. The same can be said to be true of Graham in North Carolina. It certainly was true of Taylor in Idaho.

In November Mr. Thomas, who was the author of the last omnibus bill for socialized medicine, was beaten in Utah, a small state where again the effect of a single issue can be recognized.

In Milwaukee Andrew Biemiller, who was the most vicious and vitriolic critic of medicine in Congress, was defeated, and Mr. Biemiller has stated that that was the cause of his defeat.

Mr. Sullivan in Omaha had the same experience.

After the election, when the Republicans broadcast a meeting to honor their new members of Congress, several members addressed that meeting. I happened to hear it by accident as I was going home from my office. I pushed the top button in my car radio, and I heard the announcer say, "Senator Taft will make the principal speech."

Senator Taft said, in the course of his remarks, that almost everywhere in the country where socialized medicine had been an issue, that the proponent of it had gone down to defeat. He said the reason that had occurred was that Americans were not willing to entrust their medical care to centralized government. He did not say "this administration." I believe he meant any administration at any time, and I think therein probably lies the conclusion one could draw.

This all adds up to tremendous progress, but let us not delude ourselves. The battle is not won. There is no room for complacency at this time. We can't afford to relax. We have a tremendous responsibility as citizens.

Some people may think that this is a self-serving remark on the part of the medical profession when I voice it, but I feel we have a tremendous responsibility as citizens and as doctors to the preservation of good medical care in this country.

I feel there is no question, based upon history and based upon the federal government administration of medical care programs in this country, that were we to have any variety of federal compulsory health insurance it would inevitably lead to deterioration of medical care. We have an obligation to ourselves to remain a free profession because only if we remain a free profession can we fulfill our obligation. Because most of us are getting along beyond the apex of our active lives, we ought to consider that we have that same obligation to protect the future freedom of our successors.

To do this we have to meet certain problems. We have recognized for a long time that the physician has a dual responsibility to his patient. He must render to him the best medical care he is able, and

he must treat him fairly in all respects. If one extends that thinking to the medical profession and the public, do we then not have an obligation to see that medical care is brought progressively within easier reach of those who require it? Some might object that we do not have that moral obligation. Perhaps we don't have a greater moral obligation to do so than do people in other spheres of activity who provide essential service to do the same in their own fields. Certainly the traditions of service of our profession, and certainly our own enlightened self-interest dictate that we do so.

At the same time we must adhere to proven methods, and we must expand and improve voluntary health insurance. When I say "improve voluntary health insurance" I am not exactly certain what the nature of improvement should be. There are students of the problem who feel that we have perhaps paid too much attention to comparatively minor illness, and too little attention to graver illness. That may be the case, but all over the country experiments of various types are going on, and shortly there will begin in Santa Clara County an experiment which ought to provide part of the answer to that question.

Let us not resist change or accept change simply because it is change. Let us weigh every proposal for change and let us measure it by two criteria. Does it contribute to the medical welfare of the people, and does it respect the rights and legitimate interests of the profession?

Then let us make changes for reasons. Let us make them gradually. Precipitate change might easily result in much greater harm than a situation which we think is not an ideal one at the present time.

At the present time we face on the national level substantially the same situation that we faced here in 1947. Within the past three months I have been east a number of times. In the course of these trips I have encountered some interesting people, Senator Taft, Senator McClellan, James Byrnes, who has held nearly every office in this country except that of President; Mr. Harold Stassen, whom I met by accident in the airport in Chicago and with whom I spent half an hour; Dave Beck, the executive vice-president of the Teamsters Union; Becker of the UAW, CIO; and Mrs. Anna Rosenberg. I have discussed these things with them.

Again, there is one salient, outstanding point of agreement. These people represent very divergent political points of view. They are quite different people, but in their minds there is one salient conviction, we must have in this country realistic and very extensive voluntary health insurance, or ultimately our efforts will have gone for naught because the government will enact some sort of a scheme.

Too often we tend to have tubular vision. We tend to focus on some small item which may appear to us at the moment to be tremendously important. We lack the full field of vision which allows us to see the entire problem, and the more emotional we become, the narrower becomes the tubular vision.

This is a dignified, deliberative body. Debate is usually on an extremely high level. It should be devoid of emotion. It should have general welfare as its basis.

I think we must consider here the consequences of what we do. California has been a leader in American medicine, and a leader in the American Medical Association, as is demonstrated by the acceptance by the Association without change of a semicolon of the Declaration of Principles drafted in December 1948.

What is done in this state has tremendous impact over the entire country; far more so than one would expect. We are the second largest state now and we have been pioneers in opposing socialized medicine and in voluntary health insurance.

We will be judged, let us remember, by what we do. We can't talk without performing. Let us consider very carefully what is done in our meetings, and what we decide. Let us deal with things on a factual, sound, broad-gauge basis. The failure of any major plan in this country, or sufficiently radical alteration in the plan to indicate that it was a failure, would be the greatest catastrophe which could occur to American medicine.

Let us realize our responsibilities to the people of California, to California medicine, to the people of the United States, and to American medicine. Let us calmly adjust our differences of opinion and thoughtfully work out such changes as we may think are indicated.

I have great confidence in the medical profession of this country, and particularly the medical profession of my own state in its capacity and its desire to do that. Thank you very much. (Applause.)

. . . Vice-Speaker Charnock now resumes the chair. . . .

VICE-SPEAKER CHARNOCK: Thank you, Dr. Cline.

The next order of business is the Secretary's announcement of the Council's selection of place for the 1952 Annual Session. Mr. Secretary!

SECRETARY DANIELS: Mr. Speaker, the Council has selected Los Angeles for the 1952 meeting. (Applause.)

VICE-SPEAKER CHARNOCK: Thank you, Mr. Secretary.

The next order of business is the election of officers. Nominations are now in order for the office of the President-Elect. The chair recognizes Dr. Jay J. Crane.

DR. JAY J. CRANE (Los Angeles County): Mr. Speaker, officers, members of the House of Delegates: I wish to nominate Lewis A. Alesen for President-Elect. He needs no introduction. There is no man, no doctor in California, more worthy and more capable of holding that high office. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Mulfinger of Los Angeles County.

DR. CARL L. MULFINGER (Los Angeles County):

Mr. Vice-Speaker and members of the House of Delegates: It is very rare for a man to have the opportunity to nominate his ex-roommate from his college days to such a high office as President-Elect of the California Medical Association.

Dr. Alesen has performed in this community not only as an outstanding surgeon, but as a fine citizen. He has done so many things here that are worthy of mention but can't be mentioned. I nominate him, not only on the basis of his professional accomplishments but on the basis of his accomplishments as a citizen. (Applause.)

VICE-SPEAKER CHARNOCK: The name of Dr. Lewis A. Alesen has been placed in nomination. Are there any further nominations for the office of President-Elect? The chair, hearing no other nominations, declares the nominations closed. They are closed.

How will you vote?

. . . There were calls of acclamation. . . .

VICE-SPEAKER CHARNOCK: All those who are in favor of Dr. Lewis A. Alesen for President-Elect will signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

VICE-SPEAKER CHARNOCK: The chair is deeply honored to declare Dr. Lewis A. Alesen elected President-Elect. (Applause.)

PRESIDENT-ELECT ALESEN: Members of the House of Delegates: If I were Demosthenes, and if my poor feeble tongue didn't twist around words, I would like to make an appropriate speech.

My voice is thick. I would rather cry. Let's get along with the work. (Applause.)

. . . Speaker Alesen now resumes the chair. . . .

SPEAKER ALESEN: The next office is that of the office of the Speaker. The chair will entertain nominations for that.

DR. RICHARD O. BULLIS (Los Angeles County): Mr. Speaker and members of the House of Delegates: I would like to place in nomination the name of Donald Charnock for Speaker of the House of Delegates. (Applause.)

SPEAKER ALESEN: The name of Dr. Donald Charnock has been placed in nomination as Speaker of the House of Delegates. Are there other nominations? The chair, hearing no further nominations, declares them to be closed. How will you vote?

. . . There were calls of acclamation. . . .

SPEAKER ALESEN: All in favor of electing Dr. Donald Charnock as Speaker of the House signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: Mr. Secretary, will you cast the ballot?

The next office is the office of Vice-Speaker. Nominations are in order for that office.

DR. ARTHUR A. KIRCHNER (Los Angeles County): Mr. Speaker, members of the House of Delegates: I would like to place in nomination the name of a man who has had considerable experience in political medicine, for Vice-Speaker of the House. His experience extends from a local level to a national level. At the local level he has been a Councilor for two terms. He has been chairman of our local Los Angeles fee complaints committee, chairman of the Los Angeles County administrations committee, chairman of the Los Angeles County civil service medical appeals committee.

At the state level he has been a state councilor for two years, 1947 through 1949. At the national level he has been an Alternate Delegate to the American Medical Association for two years.

More than that, he has served as a Delegate to the American Medical Association for one term.

I feel, and I am sure you do, that he has earned his spurs, and it gives me great pleasure to place in nomination for Vice-Speaker of the House of Delegates the name of Eugene F. Hoffman, Los Angeles. (Applause.)

SPEAKER ALESEN: The name of Dr. Eugene F. Hoffman has been placed in nomination for the position of Vice-Speaker. Are there other nominations?

DR. VERNE GHORMLEY (Fresno County): Mr. Speaker, members of the House of Delegates: I do not have the ability, nor do I have the intention, of claiming the role of a plaintive voice of the minority views from the land of the cotton bowl and the oil well. I realize in the larger metropolitan areas we have a greater preponderance of abilities maturing over a longer period of time that are quite capable of holding these larger jobs. I do not detract from their other honor; at the same time I do not wish to detract from any you might give to individuals from smaller localities.

We can remember that such men as Abraham Lincoln, Mark Twain, and even the backbone of medical practice, the country doctor, come from the small, rural districts. For this reason I would like to submit for consideration the name of an individual who, while he has not been known as well, possibly, in medical circles in this part of the country as elsewhere, is a man, however, well known in his own sphere of influence locally in the area of the central part of the state as well as statewide in some considerations. He is an outstanding physician, he is a good parliamentarian. He thinks in a straight line. He owes no one any allegiance, and owes nobody any promises. For this reason, gentlemen, I would like to submit the name of Dr. Henry A. Randel of Fresno. (Applause.)

SPEAKER ALESEN: The name of Dr. Henry A. Randel of Fresno has been placed in nomination for the office of Vice-Speaker of the House of Delegates. Are there further nominations?

DR. SOPHIE L. GOLDMAN (Kern County): While it is not necessary to second nominations, it is a pleasure and an honor for me to second the nomination of Dr. Henry Randel of Fresno for Vice-Speaker. (Applause.)

SPEAKER ALESEN: Are there additional nominations?

DR. J. E. YOUNG (Fresno County): Mr. Chairman, I too, would like to second the nomination of Dr. Randel. He comes here with only one purpose in mind, and that is to serve the profession of which he has been a good member in our locality. We recommend him to you because he has been a source of strength and advice to us locally, and in the San Joaquin Valley. We feel he is particularly well located geographically for this position because of the fact he is in the San Joaquin Valley. The San Joaquin Valley is becoming more and more important in the affairs of this state, both politically and economically. We are certain he has the problems of the profession at heart, and I am certain he will serve you well. That is his motive for running for this office. (Applause.)

SPEAKER ALESEN: Are there further nominations?

DR. JAMES E. FELDMAYER (Tulare County): Mr. Speaker, Delegates: I, too, would like to second the nomination of Dr. Henry Randel of Fresno for the office of Vice-Speaker. We all know at the present time there is a great burden on organized medicine, and I feel Dr. Randel would continue the good work that our officers have done in the past. (Applause.)

SPEAKER ALESEN: Are there any further nominations? If not, the chair will declare the nominations closed. We will pass out the ballots, please, Mr. Hunton. We will have a committee of tellers. Dr. Carson of San Francisco, Dr. Donaldson of Orange, and Dr. Franklin Mead of Riverside, will you please act as tellers?

There are two nominees. Will you place their names on the board, please, Mr. Hunton?

We are voting on the office of Vice-Speaker of the House of Delegates.

While we are proceeding with the balloting, I think we can go ahead with the announcement and election of the District Councilors. As you know, we are now working under the new Constitution, and the District Councilors were elected yesterday, 24 hours prior to the second meeting of the House of Delegates, which is in session at this time.

Will the chairman in each instance arise in numerical sequence and announce the name of the selected Councilor?

District No. 1, please.

A MEMBER: Dr. Francis E. West.

SPEAKER ALESEN: Dr. Francis E. West has been elected Councilor from District No. 1. Is there a challenge? Hearing none, the chair declares the election completed.

District No. 2.

A MEMBER: Dr. John D. Ball.

SPEAKER ALESEN: Dr. John D. Ball has been elected Councilor from District No. 2. Is there any challenge? Hearing none, the chair declares the election completed.

District No. 3.

A MEMBER: District No. 3, Los Angeles County, is Dr. H. Clifford Loos.

SPEAKER ALESEN: District No. 3 announces the selection of Dr. H. Clifford Loos. Is there any challenge? Hearing none, the chair declares the election is completed. Please proceed, Dr. Foster.

DR. FOSTER: District No. 4 is Dr. J. Philip Sampson.

SPEAKER ALESEN: Is there any challenge? If not, the chair declares the election completed. District No. 5.

A MEMBER: Dr. A. A. Morrison of Ventura.

SPEAKER ALESEN: Dr. A. A. Morrison is selected as Councilor from District No. 5. Is there any challenge? Hearing none, the chair declares the election completed. District No. 6.

A MEMBER: Dr. Neil J. Dau of Fresno has been selected as Councilor.

SPEAKER ALESEN: Dr. Neil Dau of Fresno has been selected as Councilor from District No. 6. Is there any challenge? Hearing none, the chair declares the election completed. District No. 7.

A MEMBER: Dr. Hartzell Ray.

SPEAKER ALESEN: Dr. Hartzell Ray has been declared as elected Councilor. Is there any challenge? Hearing none, the chair declares the election completed. District No. 8.

A MEMBER: Laurence Montgomery.

SPEAKER ALESEN: Laurence Montgomery has been elected from District No. 8. Is there any challenge? Hearing none, the chair declares the election completed. District No. 9.

A MEMBER: Dr. Donald D. Lum.

SPEAKER ALESEN: Dr. Donald D. Lum is selected from District No. 9. Is there any challenge? Hearing none, the chair declares the election completed. District No. 10.

A MEMBER: Dr. John W. Green.

SPEAKER ALESEN: Dr. John W. Green has been selected by District No. 10. Is there any challenge? Hearing none, the chair declares the election completed. District No. 11.

A MEMBER: Dr. Wayne Pollock.

SPEAKER ALESEN: Dr. Wayne Pollock is the selection of District No. 11. Is there any challenge? Hearing none, the chair declares the election completed.

That concludes the election of the District Councilors.

There are two Councilors-at-Large whose terms expire. Dr. Francis E. West, San Diego. Nominations are now in order.

DR. FREDERICK A. VEITCH (Riverside County): It is with pleasure that I place before this body the name of Arthur Varden of San Bernardino County to become a Delegate-at-Large from this part of the state.

SPEAKER ALESEN: The name of Dr. Arthur Varden has been placed in nomination for Councilor-at-Large to succeed Dr. Francis E. West. Are there additional nominations? Hearing none, the chair declares the nominations closed.

All those in favor of electing Dr. Arthur Varden as Councilor-at-Large, succeeding Dr. Francis E. West, signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you so cast?

Now, the term of Ivan C. Heron of San Francisco, term expiring.

DR. FRANCIS T. HODGES (San Francisco County): Mr. Chairman, it is my honor to nominate for the office of Councilor-at-Large a man known to all of you who has been tried in local and C.M.A. doings for some period of time, and who should remain in office; that is Ivan C. Heron of San Francisco.

SPEAKER ALESEN: The name of Dr. Ivan C. Heron has been placed in nomination to succeed himself as Councilor-at-Large. Are there other nominations? Hearing none, the chair declares the nominations closed.

All those in favor of selecting Dr. Ivan C. Heron to succeed himself in this post will signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you please cast the ballot?

DR. A. A. MORRISON (Ventura County): Mr. Speaker, members of the House of Delegates: Those of you who have been coming to these meetings for a long time will bear me out in this. I think we have heard many flowery words when a horse is being run. When the horse has finished a successful race, we hear nothing.

I would like to make this a motion. Our Councilor, my immediate predecessor, has served this House of Delegates for 10 years. We feel he has done a very good job locally and also in the interests of medicine in the State of California.

I would like to move, Mr. Speaker, that this House give Dr. Harry Henderson a vote of thanks for 10 years of faithful and conscientious service. (Applause.)

SPEAKER ALESEN: By your applause you have unanimously passed this resolution eulogizing Dr. Henderson.

The next item of business is that of the selection of the Delegate to the American Medical Association.

DR. E. VINCENT ASKEY (Los Angeles County): Mr. Speaker and ladies and gentlemen: In the last couple of days I have been besieged by a lot of people as the chairman of your delegation to the American Medical Association, asking me for a frank expression of my opinion as to how our delegates conduct themselves, their efficiency, and whether they are good delegates. I think it is only fair that I give my opinion to you as the House and not to individual members.

I tried to tell you some of the facts at the meeting yesterday, but apparently I didn't get it over, or some of you were not here, as to how I felt in regard to it. May I say that I have never been associated in my lifetime with a group of men who took their responsibility so keenly as every member of our delegation. I think that they go there with the idea of developing the best for the medical profession of America that they can. They go there with the idea of bringing to our national body the expression of opinion of you men, and the men that you represent.

They have always, in my opinion, carried out your directions to the best of their ability, and intend to do so.

Now, there are five men here, and I think it is only right that I give you an estimate of each of them.

Dr. Robertson Ward of San Francisco, term expiring. He has been a tower of strength. He is now chairman of the American Medical Association Committee for Chronic Diseases.

A MEMBER: Mr. Chairman, a point of order. Is the speaker making a nomination or delivering a eulogy?

SPEAKER ALESEN: All right, Dr. Askey, proceed.

DR. E. VINCENT ASKEY (Los Angeles County): I did not hear you, Mr. Speaker.

SPEAKER ALESEN: Proceed. I believe your remarks are in order, Dr. Askey. (Laughter.)

DR. E. VINCENT ASKEY (Los Angeles County): Thank you very much, gentlemen. If you want me to sit down I will be happy to do it. (Applause.)

I am trying to tell you my opinion of these men. I am not going to play favorites; don't worry.

Robertson Ward always has been on the Blood Bank Commission. He has, in these conditions in which there is so much controversy, been a tower of strength in the House of Delegates of the American Medical Association. He is revered by every member that I know of in the American Medical Association House of Delegates. In my opinion he is a very able man and has ably represented you.

Sam J. McClendon, a Past President of your association, a man who was the chairman of the delegation just ahead of Dwight Murray, a man who carried the ball when you know the California Medical Association did not stand in its enviable position which it has now attained. Sam McClendon has given yeoman service.

Eugene Hoffman had the unfortunate happenstance to follow that man who is awfully hard to replace, and I refer to a Past President, Dr. Lowell Goin. Having followed Dr. Lowell Goin as your Speaker, I know what a job that was. Eugene Hoffman followed that man and he has made a place in the American Medical Association. I was talking to a man now who said, "I have never seen that man when he did not work to the fullest extent. When you turn over anything to him you forget it. You know it will be done." That is my opinion of Dr. Hoffman.

Dr. John W. Green, who has just been reelected as Councilor of this Association, for years has been

a tower of strength. Pete Green fortunately has the ability to get around and meet people and get them on their home grounds, and they trust him. Pete Green has never talked to a man but what he has practiced in that man's town for six years out of his life. I counted it up one time and Pete Green had practiced 67 years in the United States in different places. (Laughter.)

As to Lewis A. Alesen, I don't need to say anything more. You know him. He is an able speaker. You trust him. He is a fine addition to our delegation.

The point I am making, gentlemen, is this: Each one of these incumbents, in my opinion, is of a high type; they are men who could be trusted in anything that you would give them. I want it distinctly understood, however, I am not making a pitch for any one of these as against any of them. May I let you know that we, your delegates, will work with anybody that you elect. We do have the confidence in these men and I want that understood. (Applause.)

SPEAKER ALESEN: Yes, Dr. McGuinness.

DR. JOSEPH S. MCGUINNESS (San Francisco County): Mr. Speaker and Delegates: It is a pleasure for me to nominate to this position as Delegate to the American Medical Association a man whom I have come to know well in the last two years. I think you all have known him a bit longer. I believe that Dr. Chief Bender has great possibilities for this job. You know what he has done here. We know that he has done a terrific job in San Francisco.

As far as his connections with the American Medical Association, we were hosts, and he was our main host of the American Medical Association last year, and I believe the members of that organization honor him and respect him, not only as an outstanding physician but an outstanding person who works for the betterment of medical care. Thank you. (Applause.)

SPEAKER ALESEN: Dr. Magoon.

DR. LESLIE B. MAGOON (Santa Clara County): There is nothing I can say that will add to the stature of Chief Bender in your minds. I limit myself to seconding his nomination as a delegate to the American Medical Association.

SPEAKER ALESEN: Dr. Teall of Sacramento is recognized.

DR. RALPH TEALL (Sacramento County): Again not wishing to impose on your time or good nature, throughout the state many of us have come to know the Chief, and have admired the things he stands for. I, too, would like to take this opportunity to second his nomination for this position. (Applause.)

SPEAKER ALESEN: Dr. Alson Kilgore of San Francisco is recognized.

DR. ALSON KILGORE (San Francisco County): Mr. Speaker, members of the House of Delegates: I am sure I am right that the nomination of Chief Bender carries no implication whatever of criticism of the service that Dr. Robertson Ward has made in the interests of California in the American Medical Association, but it rather grows out of a feeling that there should be a more frequent rotation of service among the servants of this Association. I will agree with that in principle. I don't think this Association has any right to expect the amount of service over the length of time that some of our members have given, and it is better for the affairs of this Association and its various offices to be spread around among the members.

But some of us feel that the representation of the California Medical Association to the American Medical Association stands in a little different light, that the service and effectiveness of a man in the American Medical Association is materially enhanced by his experience, and by his acquaintances which have been built up in that body during the time he has served there.

It seems to me perhaps this is an issue which might well be left to the House of Delegates to settle, and I therefore take pleasure in placing in nomination the name of Dr. Robertson Ward to succeed himself. (Applause.)

SPEAKER ALESEN: The name of Dr. Robertson Ward has been placed in nomination to succeed himself. Are there other nominations?

DR. H. CLIFFORD LOOS (Los Angeles County): Mr. Speaker, a point of order. Are we voting for one office at the present time, or do we toss in all of our nominations for any of the vacancies?

SPEAKER ALESEN: We will have to take one at a time, the particular vacancy involved.

DR. H. CLIFFORD LOOS (Los Angeles County): Would you name the vacancy at the time it comes up that is involved?

SPEAKER ALESEN: There are five.

DR. H. CLIFFORD LOOS (Los Angeles County): And will you name them as they come up?

SPEAKER ALESEN: Yes, sir.

This is for the vacancy of Dr. Robertson Ward, term expiring.

Are there any further nominations?

DR. SIDNEY J. SHIPMAN (San Francisco County): I have known both of these men for a long time, and I respect them both very highly. Dr. Bender, since I have been chairman of the Council, has been unstinting in his value to the California Medical Association. Nevertheless, in this instance I am concerned about two things: One, that neither Dr. Ward nor anyone else should feel that his service has been of an inferior quality; that he has had only one full term; that he deserves another. And to be sure this was true I asked members of the delegation and was told his service was of an outstanding character. It, therefore, gives me great pleasure to second the nomination of Dr. Robertson Ward. (Applause.)

SPEAKER ALESEN: Are there additional nominations? Hearing none, the chair declares the nominations closed. The vote will be by ballot.

We will have another board of tellers: Dr. Paul Foster of Los Angeles, Harold Behneman of Riverside, and Leopold Fraser of Alameda-Contra Costa, will act as tellers. Will you please proceed. This is ballot number three.

The candidates are Dr. William Bender of San Francisco and Dr. Robertson Ward of San Francisco for the term of Dr. Robertson Ward as Delegate to the American Medical Association.

The next post is that of Sam J. McClendon, term now expiring, as Delegate to the American Medical Association. Nominations are in order.

DR. JOHN D. BALL: Mr. Speaker, members of the House of Delegates: I am going to deliver a eulogy and also propose a nomination. I nominate Sam McClendon to succeed himself. (Applause.)

SPEAKER ALESEN: Dr. Sam J. McClendon has been nominated to succeed himself. Are there other nominations? Hearing none, the chair declares the nominations closed.

All those in favor of selecting Dr. Sam J. McClendon to succeed himself please signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: Dr. McClendon is declared elected. Mr. Secretary, will you please cast the ballot?

The next term is that of Eugene F. Hoffman.

Dr. Loos is recognized.

DR. H. CLIFFORD LOOS (Los Angeles County): I, of course, wish to nominate Dr. Eugene Hoffman to succeed himself. I had prepared a very fine speech, but Art Kirchner and Vince Askey took all of the fire away and there is nothing more to say except that Gene Hoffman should be sent back. We need him. (Applause.)

SPEAKER ALESEN: The name of Dr. Eugene F. Hoffman has been placed in nomination to succeed himself as delegate to the American Medical Association. Are there other nominations? Hearing none, the chair declares the nominations closed.

All those in favor of the selection of Dr. Eugene F. Hoffman to succeed himself as delegate to the American Medical Association please signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you so cast.

The next post is that of John W. Green, whose term expires. The chair recognizes Dr. George Dawson of Napa.

DR. GEORGE DAWSON (Napa County): Mr. Speaker, members of the House: I wish to correct Dr. Askey. He informed us a few minutes ago that Dr. Green had practiced medicine for 67 years. It has only been 43 years, but I maintain that 43 years is long enough for a man in his part of the state to be recognized as Mr. Medicine Himself, Mr. Anti-Socialism Itself, and I take pleasure in nominating Dr. John W. Green. (Applause.)

SPEAKER ALESEN: The name of Dr. John W. Green has been placed in nomination to succeed himself in the post of delegate to the American Medical Association. Are there any further nominations for this post? Hearing none, the chair declares the nominations closed.

All those in favor of electing Dr. John W. Green to succeed himself please signify by saying, "Aye."

. . . The motion was put to a vote and it was unanimously carried. . . .

SPEAKER ALESEN: It is so ordered. Mr. Secretary, will you so cast?

. . . Vice-Speaker Charnock now assumes the chair. . . .

VICE-SPEAKER CHARNOCK: The next is the name of Dr. Lewis Alesen, term expiring.

DR. WILBUR BAILEY: Mr. Speaker: There are times when there is no need to make a speech; the record speaks for itself. It gives me great pleasure to nominate Dr. Lewis Alesen to succeed himself. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Alesen has been nominated. Are there other nominations for this office? Hearing none, the chair declares the nominations closed.

All those in favor of electing Dr. Alesen to succeed himself will please signify by saying, "Aye."

. . . The motion was put to a vote and carried. . . .

VICE-SPEAKER CHARNOCK: Mr. Secretary, will you so cast?

At this time, ladies and gentlemen, we had promised C.P.S. that they could take over.

Just a moment. We will ask Secretary Daniels to announce the ballots on the post of Vice-Speaker.

SECRETARY DANIELS: The vote for the Vice-Speaker is as follows: Henry Randel, Fresno, 137 votes; Dr. Hoffman, Los Angeles, 103. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Randel of Fresno County is declared elected to the post of Vice-Speaker.

At this time we will turn the gavel over to Dr. Doughty, President of the California Physicians' Service, who will conduct their meeting. At the end of that meeting we shall reconvene as the House of Delegates of the California Medical Association.

. . . Following announcements the Tuesday Afternoon Session of the California Medical Association adjourned at 3:00 p.m. to reconvene after the meeting of the California Physicians' Service. . . .

TUESDAY EVENING SESSION
MAY 15, 1951

The Tuesday Evening Session was held in the Music Room of the Biltmore Hotel, and was called to order at 8:00 p.m. by Vice-Speaker Donald Charnock, who presided.

VICE-SPEAKER CHARNOCK: The first order of business will be the report on Ballot No. 3. Mr. Secretary.

SECRETARY DANIELS: Mr. Vice-Speaker, the vote on Ballot No. 3 for delegate to the American Medical Association, Bender 80 votes, Ward 156. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Ward is declared elected.

DR. WILBUR BAILEY: Mr. Speaker, I would like to see what we got for the money. I don't mean it that way, but we just elected trustees of the C.M.A. and of the C.P.S., and I think it would be in order for you to introduce the newly-elected gentlemen to the House.

VICE-SPEAKER CHARNOCK: We have 11 Councilors that have just been elected. As I call them off, will you all stand.

Councilor, District No. 1, Dr. West. (Applause.)

Councilor, District No. 2, Dr. Ball. (Applause.)

Councilor, District No. 3, Dr. Loos. (Applause.)

Councilor, District No. 4, Dr. Sampson. (Applause.)

Councilor, District No. 5, Dr. Morrison. (Applause.)

Councilor, District No. 6, Dr. Dau. (Applause.)

Councilor, District No. 7, Dr. Ray. (Applause.)

Councilor, District No. 8, Dr. Montgomery. (Applause.)

Councilor, District No. 9, Dr. Lum. (Applause.)

Councilor, District No. 10, Dr. Green. (Applause.)

Councilor, District No. 11, Dr. Pollock. (Applause.)

Gentlemen, those are your Councilors.

The next order of business will be the election of alternates to the American Medical Association. Incumbents, Anthony B. Diepenbrock, alternate for Robertson Ward.

I will now entertain nominations.

DR. ROBERTO ESCAMILLA (San Francisco County): Mr. Chairman, I would like to place in nomination the name of Dr. Henry Gibbons of San Francisco. Dr. Gibbons is one of our teachers at the Stanford Medical School; one who has shown more than the usual political awareness and political adroitness, and I am pleased to place his name in nomination on behalf of the San Francisco delegation.

VICE-SPEAKER CHARNOCK: Do I hear any other nominations? The chair hearing none declares the nominations closed.

All those in favor of Dr. Henry Gibbons will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: Next is Dr. Walter Cherry, alternate for Dr. Sam J. McClendon.

DR. J. B. PRICE (Orange County): Dr. Walter Cherry, who has been both Councilor and alternate delegate, has asked that he not be carried on as the alternate delegate to the American Medical Association. It is my pleasure to place in nomination in his place Dr. A. E. Moore of San Diego.

VICE-SPEAKER CHARNOCK: Dr. A. E. Moore of San Diego. Are there any other nominations? The chair hearing none declare the nominations closed.

All those in favor of Dr. Moore as alternate to Dr. McClendon will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: Dr. Moore is elected.

Alternate to Eugene F. Hoffman, incumbent, Frederic S. Ewens.

DR. J. LAFE LUDWIG (Los Angeles County): Mr. Speaker and members of the House of Delegates: I am very happy to offer in nomination to succeed himself a confrere of mine as alternate to the American Medical Association, a member of the Los Angeles County Medical Association, a man who is doing a fine job for medicine, Dr. Frederic Ewens. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Frederic Ewens has been placed in nomination. Are there any other nominations? The chair hearing none declares the nominations closed. They are closed.

All those in favor of Dr. Ewens will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: Alternate to John W. Green, Frank A. MacDonald, incumbent.

DR. ORRIN COOK (Sacramento County): We believe that the careful selection of our American Medical Association delegates is important, and we believe the selection of alternates is important. We are still suffering because insufficient attention was paid to the selection of the Vice-President of the United States. (Laughter and applause.)

We have a man in mind who has served as Councilor for several years, and as Trustee of C.P.S., who knows our problems intimately and has also served in this capacity for several years and knows his way around the American Medical Association.

I would like to place in nomination the name of Dr. Frank MacDonald to succeed himself. (Applause.)

VICE-SPEAKER CHARNOCK: Dr. Frank MacDonald has been nominated to succeed himself. Do I hear further nominations? Hearing none, the chair declares the nominations closed.

Those who are in favor of Dr. Frank MacDonald will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: Dr. MacDonald is elected.

Alternate to Lewis A. Alesen, John Ball, incumbent.

DR. ARTHUR VARDEN (San Bernardino County): I wish to place in nomination the name of Dr. John Ball to succeed himself.

VICE-SPEAKER CHARNOCK: The name of Dr. John

Ball has been placed in nomination to succeed himself. Do I hear any further nominations? Hearing none, the chair declares the nominations closed.

Those who are in favor of Dr. Ball signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: Dr. Ball is elected.

The next order of business is the election of two members to the C.M.A.-C.P.S. Liaison Committee. Nominations for these two positions are in order.

Dr. Cass, do you care to tell us about this?

PRESIDENT DONALD CASS: It looks as though we appointed or ordered a new committee to take care of this detail. Last year they appointed this committee on the recommendation of Dr. Bender and Orrin Cook's committee. Now, if we have this Liaison Committee in addition to that, we are going to have another Chandler Committee and we will duplicate our efforts. I would suggest to those who appoint the new Liaison Committee that my own recommendations would include Dr. Bender.

VICE-SPEAKER CHARNOCK: May we have nominations for these two positions? The two positions are to the C.M.A.-C.P.S. Liaison Committee.

DR. REUBEN ZUMWALT (San Francisco County): I nominate Dr. Bender.

VICE-SPEAKER CHARNOCK: Dr. Bender has been nominated.

DR. HARTZELL RAY: I would like to nominate Dr. Farthing from San Mateo County, who introduced the resolution.

VICE-SPEAKER CHARNOCK: We have two nominations. Do I hear any others? The chair hearing no other nominations declares them closed.

Those who are in favor of Dr. Bender and Dr. Farthing being the two members of the C.M.A.-C.P.S. Liaison Committee will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: They are elected.

At this time we will have the announcement by the Secretary of the Council's nominations of members of Standing Committees. Dr. Green, chairman. Will Dr. Green please come up and give his list, chairman of Committee on Committees.

REPORT OF COMMITTEE ON COMMITTEES

DR. JOHN W. GREEN: Mr. Speaker, members of the House: We made an effort at this time to secure for you some of the best men in our Association. We have always made that effort since we felt it was the consensus of the House that perhaps it would be better for everybody concerned if some Councilor might sit on our committees.

Not being able to give you a Councilor in every instance, we have, however, in almost every instance given you a man with Councilor experience, which we feel is the equivalent of a Councilor, if not better.

The first committee is that of Scientific Work, composed as follows: Clayton Mote, San Francisco; Robert L. Dennis, San Jose; Howard F. West, Los Angeles; Albert C. Daniels, ex-officio, San Francisco; Paul C. Samson, ex-officio, Secretary of the Section on Surgery, San Francisco; James Malcolm Stratton, ex-officio, Section on Medicine, Oakland.

Committee on Public Policy and Legislation. In this instance we felt that it was to the best interest of the entire Association that we should not change this committee. We had the recommendation of Dr. Murray also to this effect that he had his legislative committee so well organized that any change in the personnel of that committee might result in a less efficient group. So, we will name the committee again as it served last year: Peter Blong, Alhambra; Dwight H. Murray, chairman, Napa; Anthony Diepenbrock, San Francisco.

Committee on Medical Defense: H. Clifford Loos, chairman, Los Angeles; Leslie B. Magoon, San Jose; Otto Diederich, Fresno.

Committee on Medical Education and Medical Institutions: Francis Scott Smyth, San Francisco; Lewis T. Bullock, Los Angeles; Laurence Montgomery, San Francisco.

Committee on Hospitals, Dispensaries, and Clinics: Howard C. Miles, Salinas; John B. Hamilton, chairman, Glendale; Jay J. Crane, Los Angeles.

Committee on Medical Economics: Arthur A. Kirchner, chairman, Los Angeles; Hollis L. Carey, Gridley; L. H. Fraser, Richmond.

Committee on Associated Societies and Technical Groups: J. Norman O'Neill, Los Angeles; Robert A. Scarborough, chairman, San Francisco; Hartzell Ray, San Mateo.

Committee on History and Obituaries: E. T. Remmen, Glendale; Dewey R. Powell, Stockton, chairman; J. Marion Read, San Francisco.

Committee on Industrial Practice: Jerome W. Shilling, Los Angeles, chairman; Raymond M. Wallerius, Sacramento; E. Vincent Askey, Los Angeles.

Committee on Postgraduate Activities: Carroll B. Andrews, Sonoma; Edward C. Rosenow, chairman, Pasadena; John D. Ball, from the Council, Santa Ana.

Committee on Public Relations, and this we thought was one of our most significant and fine committees. I think we spent more time on this committee than any other in our deliberations on who might be on this committee: Dwight H. Murray, Napa; Arthur A. Kirchner, Los Angeles; Robert A. Scarborough, San Francisco; H. Gordon MacLean, Oakland; Lewis A. Alesen, Los Angeles; J. Lafe Ludwig, Los Angeles; Frank A. MacDonald, Sacramento.

Physicians' Benevolence Committee. We are retaining the old committee for two reasons: One is that it has been an eminently satisfactory committee. Another is that we haven't found too many takers for this job. (Laughter.) Elizabeth Mason Hohl, Los Angeles; John W. Sherrick, Oakland; Axcel E. Anderson, chairman, Fresno.

This is a new committee now that we are naming for you, the Committee on Military Affairs and Civil Defense: Frank F. Schade, Los Angeles; William L. Bender, San Francisco; Justin J. Stein, chairman, Los Angeles.

In reviewing the reports of the Standing Committees for 1950, your committee feels and notes the lack of activity in some groups which we feel also is partly due to a lack of initiative on the part of some members of the Standing Committees, and also partly due to the failure of the Council to properly funnel information and direction to these committees. Respectfully submitted, Jay J. Crane, Ivan C. Heron, C. V. Thompson, John W. Green, chairman.

VICE-SPEAKER CHARNOCK: Thank you very much, Dr. Green, and we thank all your committee for this magnificent piece of work.

We will have to have the House approval of these committees. All those who are in favor of approving these committees will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: They are approved.

The next order of business is the Report of Reference Committee No. 1 on Reports of Officers, the Council and Standing and Special Committees, J. Lafe Ludwig, chairman. Dr. Ludwig!

REPORT OF REFERENCE COMMITTEE No. 1

DR. J. LAFE LUDWIG: Mr. Speaker, members of the House of Delegates: I wish to express my thanks to Dr. J. Needham Martin of San Bernardino County and Dr. James B. Graeser of Alameda County for their fine cooperation and assistance on the work of Reference Committee No. 1.

Section One:

Your committee has reviewed the reports of the General Officers, with the exception of the report of the Secretary-Treasurer and the Executive Secretary, whose reports will be reviewed by Reference Committee No. 2. We wish to offer special commendation to our retiring President, Dr. Donald Cass, and to the President-Elect, Dr. H. Gordon MacLean, for their untiring efforts this past year in traveling throughout the state to bring the actual working of the California Medical Association to each and every member of the component county medical societies and to the members of the Woman's Auxiliaries.

Your committee recommends the approval of these reports. Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: So ordered.

DR. J. LAFE LUDWIG:

Section Two:

Your committee has reviewed the report of the Council. We wish to give special commendation to the Council of the California Medical Association for contributing $100,000 to the non-profit corporation of the A.M.A. for the subsidization of medical schools.

Your committee recommends the approval of this report, Mr. Speaker. I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded we accept this section of the report. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. J. LAFE LUDWIG: Your committee feels that it is apropos at this time to take up the three resolutions which were presented to it.

A supplemental resolution as submitted by the Council is hereby presented for your action:

Resolved, That the House of Delegates of the C.M.A. express its complete support of the Student American Medical Association and urge upon the component county medical societies their full cooperation with the chapters of this organization which are or will be formed in the medical schools of California; and be it further

Resolved, That the House of Delegates adopt a policy of making available to the California members of the Student American Medical Association annual subscriptions to the official journal CALIFORNIA MEDICINE at an annual rate of $1 per year, the additional $2 per year required by postal regulations to be supplied by the Association in its annual budget; and be it further

Resolved, That the adoption of the above recommendation would make the further publication of *Future M. D.* unnecessary, wherefore its publication should be discontinued and the thanks of the Association extended to its editors who have so capably filled the gap during the formation of the Student American Medical Association.

Your committee has made the following addition: We recommend that a page of CALIFORNIA MEDICINE be devoted to the discussion of problems of the medical student, intern, and resident. The committee further recommends that adequate space be given to economics as applied to the practice of medicine.

Mr. Speaker, we recommend the adoption of the resolution as amended.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted and so recorded.

DR. J. LAFE LUDWIG: Another supplemental resolution as submitted by the Council is hereby presented for your action.

Gentlemen, before I start this resolution I would like to call your attention to the wording in this resolution. It applies to EMIC, Emergency Maternity and Infant Care, as applied during World War II. There is some talk now of this resolution being brought before the Congress of the United States. This resolution is being offered by the Council of the California Medical Association. I again ask your indulgence in paying special attention to the wording in this resolution:

Resolved, That in view of certain legislation now pending in Congress on the subject of providing medical services for the wives and infant children of enlisted men in the Armed Forces, the California Medical Association go on record as expressing support of the principle of giving such aid to the families of our fighting men in cases of hardship, without at the same time creating any interference with the practice of medicine, choice of physician, or with current hospitalization procedures, and wherever possible through the use of existing medical care and hospitalization prepayment plans working within the framework of medical and hospital organizations.

Mr. Speaker, we recommend the adoption of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: Is there any discussion to this? It has been moved and seconded that we accept this section of the report. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. J. LAFE LUDWIG: Your committee feels that the resolution offered by Dr. Burt L. Davis of San Mateo County, Resolution No. 10, should be taken up at this time.

Mr. Speaker, we recommend the adoption of this resolution.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: Is there any discussion?

. . . There were calls of "What is the resolution?"

VICE-SPEAKER CHARNOCK: There is still some question about this resolution, Dr. Ludwig. Perhaps you could read it.

DR. J. LAFE LUDWIG: Resolution No. 10 as proposed by Dr. Burt L. Davis of Santa Clara County reads:

"WHEREAS, There are many naval and military posts in California located within reasonable distances of established civilian medical facilities; and

WHEREAS, The personnel in these military posts frequently maintain their families in these neighboring communities; and

WHEREAS, A considerable portion of the time of the medical departments of the Armed Services is required in attending to the dependents of the military personnel and not to active military problems; and

WHEREAS, California Physicians' Service is ideally adapted for entering into a contract with the Armed Forces to render medical attention to these dependents; and

WHEREAS, Such a contract would efficiently conserve the use of medical personnel within the Armed Forces and thereby lessen the need for greater expansion of the military program; and

WHEREAS, Similar contracts with the Veterans Administration and with the Agricultural Workers, to name but two, have established the propriety and precedence for the custom of governmental agencies contracting with California Physicians' Service for medical care; now, therefore, be it

Resolved, That the House of Delegates of the California Medical Association encourage, authorize and request the California Physicians' Service to enter into negotiation with the Armed Forces for contracts whereby the families and dependents of military personnel may be cared for as private patients in the proper fashion by the civilian physicians in the neighboring communities in which they reside within this state; and be it further

Resolved, That the California Medical Association call the attention to this program of the various other state and national physicians' health plans in order that they be encouraged to enter into similar arrangements."

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there still any discussion?

DR. WILLIAM G. DONALD (Alameda-Contra Costa County): Mr. Chairman, I move to amend the next to the last paragraph by the words "providing physicians may practice without government regulations." That same motion was passed by the California Physicians' Service. The only difference is that in the next to the last paragraph the words were added, "providing that the physicians of California could practice without government regulation," and that the funds held in trust by the California Physicians' Service be not jeopardized. I offer that as an amendment to the resolution.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: The amendment has been made and seconded. We will vote first upon the amendment. Is there any discussion of this?

Those who are in favor of this amendment will signify by saying, "Aye."

. . . The motion was put to a vote and the amendment was passed. . . .

VICE-SPEAKER CHARNOCK: We will now vote on this section as amended. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed. Proceed, Dr. Ludwig.

DR. J. LAFE LUDWIG:

Section Three:

Your committee has reviewed the reports of the President of the Trustees of the California Medical Association, the Councilors, and the Councilors-at-Large.

Your committee recommends the approval of these reports.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded we accept this section of the report. Is there any discussion? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed. Proceed, Dr. Ludwig.

DR. J. LAFE LUDWIG:

Section Four:

Your committee has reviewed the report of the Legal Department. We wish to offer a special commendation to our general counsel, Peart, Baraty and Hassard. We particularly thank Mr. Howard Hassard for his efforts in behalf of California medicine.

Your committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Those who are in favor of this will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed. Proceed.

DR. J. LAFE LUDWIG:

Section Five:

Your committee has reviewed the reports of the Editor and Editorial Board of CALIFORNIA MEDICINE. We commend the editor, Dr. Dwight L. Wilbur, and the Editorial Board for continuing the high quality of CALIFORNIA MEDICINE so that it remains the outstanding publication of its type in the United States.

Your committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Those in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed.

DR. J. LAFE LUDWIG:

Section Six:

Your committee has carefully reviewed the reports of the following committees: Executive Committee, Committee on Associated Societies and Technical Groups, Auditing Committee, Committee on Health and Public Instruction, Committee on Hospitals, Dispensaries and Clinics, Committee on Industrial Practice, Committee on Medical Defense, Committee on Medical Economics, Committee on Medical Education and Medical Institutions, Committee on Membership and Organization, Committee on Publications, Committee on Public Relations, Committee on Scientific Work, the Physicians' Benevolence Committee, the Advisory Planning Committee, the Blood Bank Commission, the Committee on Rural Medical Service, the Committee on Industrial Health, the Cancer Commission and the Industrial Accident Fee Schedule Committee.

Your committee recommends the approval of these reports.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed.

DR. J. LAFE LUDWIG:

Section Seven:

Your committee has reviewed the report of the Committee on History and Obituaries. We urge the cooperation from each and every member of the California Medical Association in forwarding pertinent historical data to Dr. George H. Kress, who is writing a history of each county society.

Your committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: Is there any discussion? Those in favor of this section of the report will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed.

DR. J. LAFE LUDWIG:

Section Eight:

Your committee has reviewed the report of the Committee on Postgraduate Activities. We call attention to the supplemental report which was presented to the committee by the chairman, Dr. John Ruddock:

"Herewith is a recapitulation of expenses and activities of your Postgraduate Committee during the year 1950. Our activities have been widespread and we have succeeded in establishing an excellent liaison with the five medical schools in the State of California as well as setting a practical pattern for organized medicine to participate in and offer extension medical education on a postgraduate level to its membership.

POSTGRADUATE ACTIVITIES

Administration		$ 8,661.86
Salary, director	$6,000.00	
Office and sundries	2,661.86	
Travel		2,000.46
Director and secretary	1,066.14	
Speakers	655.27	
C.M.A. Committee	279.05	
Honoraria		2,000.00
Meals, etc., req. room, inst. speakers		739.07
Exhibit at 1950 convention		187.46
Signs and printing at institutes		98.99
		13,687.84
Registration fees collected		3,295.00
Total cost to C.M.A.		$10,392.84
No. of institutes held	5	
Total attendance	1,170	
Paid registration	659	
Nurses res. and inst.	74	
Attendance at county meetings	437	
Total cost of institutes	$4,063.28	
Average cost per person attending	5.54	
Total cost of institutes (5)	4,063.28	
Total moneys collected	3,295.00	
Total deficit	768.28	
Average cost per institute	812.65	

Your committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any discussion? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted. Proceed.

DR. J. LAFE LUDWIG:

Section Nine:

Your committee accepts the oral report of Dr. Dwight Murray, chairman of the Committee on Public Policy and Legislation. We commend him for the splendid work he is doing in our behalf.

Your committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is passed.

DR. J. LAFE LUDWIG:

Section Ten:

Your committee has reviewed the report of the Special Committee on C.P.S. administrative changes.

Your committee recommends the approval of this report.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report. Is there any discussion? Those in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. J. LAFE LUDWIG:

Section Eleven:

Your committee has reviewed the report of the C.P.S. Liaison Committee as presented on the floor of the House.

Your committee does not approve of the report because there are two controversial issues involved re C.P.S.:

1. The income ceiling; and
2. The ratification of the proposed fee schedule.

Your committee recommends that this report be not approved.

Mr. Speaker, I move the adoption of this section of the report.

Mr. Speaker, I move the adoption of the report as a whole, as amended.

VICE-SPEAKER CHARNOCK: We will first take the section. Do I hear a second to that?

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any discussion? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: This section of the report is accepted.

Now, it has been moved that we accept the report as a whole, as amended. Do I hear a second to that?

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept Reference Committee No. 1's report as a whole, as amended. Is there any discussion? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted as amended.

Thank you, Dr. Ludwig. (Applause.)

The next order of business is the report of Reference Committee No. 2 on the reports of the Secretary-Treasurer and the Executive Secretary, on Budget and Dues, Dr. Stanley Truman, chairman.

REPORT OF REFERENCE COMMITTEE No. 2

DR. STANLEY TRUMAN: Mr. Speaker and members of the House of Delegates: This committee was composed of G. Wendell Olson of Orange County, Leslie B. Magoon of Santa Clara County, and Stanley Truman of Alameda-Contra Costa County.

Your committee has reviewed the report of the Secretary and recommends the acceptance of this report. We wish to express the appreciation of the members of the House of Delegates and the members of the California Medical Association for his efforts in our behalf.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion? Those who are in favor of accepting this section of the report will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. STANLEY TRUMAN: The report of the Executive Secretary has been reviewed, and your committee recommends its acceptance as printed. We wish to express our deep appreciation of the capable services and enthusiastic help of Mr. John Hunton through the year.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. Is there any discussion? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: The report of the Treasurer has been published in the Annual Bulletin, and this has been made available to the members of the House of Delegates. It consists primarily of an audit by the certified public accountants, the auditing firm of John F. Forbes and Company.

Our committee recommends that the Auditing Committee and the Treasurer supply a breakdown of the expenses and income on the major items on a departmental basis rather than on a total basis, this to be presented in the same general form as the proposed budget.

Our committee has carefully inspected the Treasurer's report and also the report of the certified public accountants, and found both reports to be in order, and we wish to express our appreciation of the splendid work of the Treasurer of the past year.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we adopt this section of the report. All those in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. STANLEY TRUMAN: Concerning the resolution regarding distribution of CALIFORNIA MEDICINE to medical students of California, our committee feels that in view of the fact that the same subject has been disposed of by the preceding recommendation of Reference Committee No. 1 and action of this House, no action is necessary on this resolution.

A MEMBER: Which resolution?

DR. STANLEY TRUMAN: The resolution regarding the distribution of CALIFORNIA MEDICINE to medical students.

Your Reference Committee now presents to the House of Delegates the proposed budget for the fiscal year which will start next July first. Mimeographed copies are in your hands.

In presenting this proposed budget your committee wishes to call the attention of the House of Delegates to the fact that this set of figures represents primarily a guide, not a hard-and-fast ruling on the amount of income or expenditure on any particular item. The Constitution of the Association gives the right to the Council to appropriate funds for such purposes as are encompassed in the statement of the purposes of the Association and are deemed advisable by the Council as a deliberative body. Consequently, the figures now before you represent primarily an appraisal of anticipated experience, an appraisal which must be amended in accordance with specific conditions which may confront the Council during the coming year.

In drawing up a budget the Association starts with its Auditing Committee, which then takes its proposals to the Council. After the Council has passed upon a proposed budget it comes to this Reference Committee, before which any member of the House of Delegates is privileged to appear.

The policy of the Auditing Committee and of the Council is to draw up a budget along conservative lines. Items of estimated income are calculated at a little less than the normal anticipation and items of expenditure are stated in round figures which will probably provide a small surplus over actual needs. Thus there is a little leeway in the budget which may be used during the year by the Council to meet specific problems which arise and which need financial support.

The policy of the Council is to secure this elasticity by a conservative approach to the budget, in the knowledge that each year brings some special problems which cannot be foreseen at this time but which will need support before our next annual meeting.

Where the Council does make special appropriations during the year, the authenticity of such appropriations is carefully checked by the certified public accountants who audit the books of the Association.

Your Reference Committee wishes to give you this explanation of the manner in which the budget is drawn up, so that you may understand that there is no attempt to over-budget expense items or to set the annual dues at a level which would return a surplus to the Association. Surplus funds are now in excellent condition and there is no need to increase them. The one object here is to present a balanced budget which will take care of our needs for the coming year.

Your committee notes that the current allowances for automobile travel and for per diem expenses for officers and Councilors are considerably below present-day costs, and recommends that a reappraisal be made on these items on a realistic basis so that these members who devote so much time to the affairs of the Association may at least be permitted to carry on their work without personal loss. Under the old By-Laws these allowances were specified, while the new By-Laws permit more up-to-date allowances to be made.

It is the opinion of this committee that in Item No. 25 on public relations the amount of $9,000 per year now paid as retainer for a firm of public relations counsel could be more profitably spent by developing a specific department of public relations within the C.M.A. structure. We feel that the formation of this department would result in a better correlation between the activities of the C.M.A. and the county medical societies in the field of public relations, that it should be under the direction of a full-time director, and that it should be directly responsible to the Advisory Planning Committee.

Mr. Speaker, I move the adoption of this budget as presented, showing income of $423,000 and expenditures of $411,250 for the 1951-1952 fiscal year for the Association, and income of $143,250 and expense of $135,750 for the official journal.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that this section of the report be accepted. Is there any discussion?

DR. WILLIAM G. DONALD (Alameda-Contra Costa County): Mr. Chairman, there are four items in here: One for $100,000, Department of Public Relations; Public Policy and Legislation $75,000; Cancer Commission $19,000; committees' expense $20,000. I think it would be of interest to the House of Delegates to have those broken down further.

VICE-SPEAKER CHARNOCK: Dr. Lum, Director of the Budget.

DR. DONALD LUM: This item of $100,000, Department of Public Relations, will be utilized in large part in the grass-roots program which has been planned by the Advisory Planning Committee.

As you see by the budget, there is a reduction of $50,000.

As you know, *California Caravan* was discontinued as of January 1, and this $100,000 item is to continue the program that was suggested and planned one year ago. That program will be presented in detail, and is being planned in detail by the Advisory Planning Committee.

Public Policy and Legislation, you will note that there is a reduction shown in that figure. Next year the Legislature is not in session, so it was felt that amount could be reduced.

You will realize, of course, that next year will be an election year and will entail a certain amount of expense.

The figure of $19,000 of the Cancer Commission is a budget suggested by the Cancer Commission. It includes the salary of the director, plus their development of their program and the production of a certain amount of manuals. The committees' expense has been increased because it has been found that more committees have been utilized in the past year, and they have been more active as a result, with an increased expenditure.

Does that answer your question, Dr. Donald?

DR. WILLIAM G. DONALD (Alameda-Contra Costa County): Yes.

VICE-SPEAKER CHARNOCK: Dr. Donald, are you satisfied, sir?

DR. WILLIAM G. DONALD (Alameda-Contra Costa County): Partially, sir. (Laughter.)

DR. DONALD LUM: While I am here, if there are any other questions I would be very happy to answer them.

VICE-SPEAKER CHARNOCK: Are there any more questions to pose to Dr. Donald Lum regarding the budget?

DR. DONALD LUM: You will note in the budget on CALIFORNIA MEDICINE, there is one increase of $20,000 in printing. That is due to the increased cost of printing.

VICE-SPEAKER CHARNOCK: Dr. Truman, will you proceed, sir?

DR. STANLEY TRUMAN: I think the next order of business is a vote on this motion that was made and seconded.

VICE-SPEAKER CHARNOCK: It has been moved and seconded that we accept this section of the report of the budget. Is there any further discussion? Those in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. STANLEY TRUMAN: Mr. Speaker, I move that the dues for 1951-1952 be set at $40 per active member.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: That is for the calendar year 1952, is it not?

DR. STANLEY TRUMAN: I stand corrected.

VICE-SPEAKER CHARNOCK: Do you move that adoption, sir?

DR. STANLEY TRUMAN: I move that the dues for the 1952 calendar year be set at $40 per active member.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: Is there any discussion about this? It has been moved and seconded that the dues for the 1952 calendar year be set at $40. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

DR. STANLEY TRUMAN: Mr. Speaker, I move the adoption of the report as a whole.

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: Just a moment, Dr. Daniels has a question.

DR. DANIELS: I have one point to add here which may be an item of business at this time, Mr. Speaker.

The new Constitution provides: "Funds may be raised by any of the following methods: (a) publications of the association; (b) voluntary contributions; (c) bequests, legacies, devises and gifts; (d) special assessments levied by the House; and (e) in any other manner approved by the House."

Now, the Committee on Postgraduate Activities felt that their activities would be better if they charged a $5 registration fee. That was brought before the Council and approved by them. This fee is charged where each person enrolls in a postgraduate course as offered by the Postgraduate Committee, and that money is paid into the general fund, but it seems to me at least that that should be officially approved by the House of Delegates since it is mentioned as such in the new Constitution.

A MEMBER: I so move.

VICE-SPEAKER CHARNOCK: Do we have the consent of the House to take this up first, then? Is there a second to this motion?

. . . The motion was seconded. . . .

VICE-SPEAKER CHARNOCK: It has been moved and seconded that the outline for the postgraduate studies as outlined by Dr. Daniels be accepted. Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted.

It has now been moved and seconded that the report of Reference Committee No. 2 be accepted as a whole. Is there any discussion to this? Those who are in favor will signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

VICE-SPEAKER CHARNOCK: It is accepted and so recorded.

DR. STANLEY TRUMAN: May I thank the members of the committee for their efforts, and Dr. Lum for his patience and his work in our behalf.

VICE-SPEAKER CHARNOCK: May we extend our thanks to Dr. Truman and his committee for their work. (Applause.)

. . . Speaker Alesen now resumes the chair. . . .

SPEAKER ALESEN: Reference Committee No. 3, Dr. Lyle Craig, chairman. Dr. Craig is recognized.

REPORT OF REFERENCE COMMITTEE No. 3 (continued)

DR. LYLE CRAIG: Mr. Speaker, members of the House of Delegates: I would like first to thank the two crutches by whose aid I reached this point, Dr. Loos and Dr. Gibbons, who were members of the committee.

I should also like to express our thanks to Mr. Hunton's secretary, Miss Laughlin, who helped us a great deal.

We will consider first the amendments to the By-Laws which have been proposed, taking them up in the order of their presentation.

The mimeographed sheets which you hold before you contain these amendments, together with our recommendations on them. In each case, since the amendments as a rule were not very long, we have included on the same sheet the amendment followed by our recommendation.

The first amendment was presented 48 hours ago by Dr. Carson of San Francisco, regarding the addition of a paragraph prohibiting the acceptance of rebates, and reads as you see it on the manuscript. It isn't necessary, I think, for me to read it. It adds a section to Chapter XIII, Section 1. As you know, this paragraph is already in the previous document, which this replaces.

The committee discussed this measure at some length. There was no question involved as to disagreement with the ideal expressed. We were, however, uncertain as to the advisability of including in the By-Laws one isolated item from the Code of Ethics. However, we have decided in view of the preponderance of opinion expressed before the committee to recommend that this amendment do pass.

Mr. Speaker, I move we proceed to vote on this amendment.

. . . The motion was seconded. . . .

SPEAKER ALESEN: There is a motion to adopt this amendment. How will you act?

. . . There were calls of acclamation. . . .

DR. LESLIE B. MAGOON (Santa Clara County): May we discuss it?

SPEAKER ALESEN: Yes, Dr. Magoon.

DR. LESLIE B. MAGOON (Santa Clara County): No question can be raised as to the virtues of the ethical principle delineated by this proposed amendment. It is one of the more important principles of the Code of Ethics of the American Medical Association, and is also a part of the statutory law of California.

There is still another principle of ethics which some of us believe to be of even greater importance —the continued support of whose validity is vital to the preservation of the private practice of medicine as we know it. That principle provides that

corporations shall not practice medicine. It is not proposed that this principle be added to the By-Laws.

I cite these to emphasize that I agree fully with the importance of these ethical principles and the desirability of their frequent publication and wide dissemination to the profession. But I do not believe that either of these considerations justifies the inclusion of a principle of ethics in the By-Laws of this Association. Many of you will feel it is a minor matter whether or not it is so included. I hope to persuade you otherwise.

By definition, a Constitution and By-Laws constitute a specification of the purposes and of the organic structure of an association, and the partition of powers, duties and privileges between its legislative, judicial and executive bodies and officers.

The recently adopted Constitution and By-Laws do these things with commendable clarity and brevity. Two special committees of this Association and two Reference Committees of this House labored for four years to produce a streamlined document which was unequivocally easy of understanding and to which reference would be simple and quick.

This amendment, proposed even before the body is cool, represents the first effort to vitiate that accomplishment by adding irrelevant items which are not consistent with the purposes of the By-Laws. It represents the head of the camel, and it must be driven from the tent if a whole body of irrelevant amendment is not to follow. If this first step is to be followed by its logical sequels, we shall end with the whole Code of Ethics as part of our By-Laws.

The omission of this amendment will not vitiate nor weaken our Code of Ethics, nor will its inclusion strengthen their enforcement. Our new By-Laws already provide that our Association is governed by the Code of Ethics of the American Medical Association, and empowers this House to adopt such other principles of ethics as it may desire. It is a matter of legal fact that any principle of ethics adopted by us which is inconsistent with the Code of the A.M.A. is unenforceable.

May I be permitted to point out that the inclusion of a principle of ethics in the By-Laws of this Association is as inconsistent and irrelevant as the inclusion of a paragraph concerning criminal abortion in an Alcohol Beverage Control Act, a legislative maneuver which Ben Read decried before us Sunday. It need not follow that, to oppose such a maneuver, one favors criminal abortion.

On the grounds I have cited, I urge very strongly that this proposed amendment be defeated. (Applause.)

SPEAKER ALESEN: In paragraph three the word "disagreement" is printed, and it must be "agreement," "involved as to the agreement with the ideal expressed."

Dr. Gibbons.

DR. HENRY GIBBONS III (San Francisco County): Just a brief word about this amendment. Mr. Hassard says as a purist Dr. Magoon is dead right. We, however, in the committee did feel, after considerable discussion, that this particular Code of Ethics was so easily violated that it might be necessary to keep it before the attention of the medical profession and the insulary organizations, and that is the only reason we continued to keep it in the By-Laws.

Secondly, there is no reason why if somebody else feels there should be another ethical principle in the By-Laws, that couldn't be added as well.

We did feel this was important to keep before the attention of the profession.

SPEAKER ALESEN: Is there further discussion on this amendment?

. . . The question was called for. . . .

SPEAKER ALESEN: Dr. Truman.

DR. STANLEY TRUMAN: If we wish to pass a resolution of this nature, it seems to me it would be more appropriate in supporting this principle that we do pass it as a resolution instead of incorporating it in the By-Laws.

SPEAKER ALESEN: Is there further discussion?

. . . The question was called for. . . .

SPEAKER ALESEN: If not, are you ready for the question? You are voting on the adoption of the amendment to the By-Laws. All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: It being quite obvious two-thirds majority is lacking, the amendment is defeated.

Dr. Craig, will you continue?

DR. LYLE CRAIG: Amendment number two regarding the allocation of delegates in the House of Delegates, which has been introduced by Dr. Miller of San Mateo.

The amendment is before you. After hearing the discussion on the subject it was still the feeling of the committee that membership in the House should be determined by at least a majority of the 50 members which a delegate presumably represents. We, therefore, recommend that this amendment do not pass.

Mr. Speaker, I move we proceed to vote on this matter.

SPEAKER ALESEN: Now, since this is a By-Law amendment, and we are going to keep the record straight all the way through, when you vote you are voting for or against the adoption of the amendment. Is that perfectly clear? Is there discussion?

DR. A. G. MILLER (San Mateo County): The intent of the amendment is obvious. I want to call to the attention of the House that out of 39 counties or sections represented, only four have a representation of seven or more delegates. The other 35 have representation of seven or under, and it is particularly this group of seven or under for whom we thought this particular amendment would apply. Most specifically, it would apply to those groups who have delegations from two to seven. That is, the two are automatically taken care of because now, with the

new By-Laws, that is the minimum number of delegates. It will mean in brief that some of our delegations in the counties in that group with two to seven delegates will lose a delegate on the change of the amendment.

Therefore, I ask you to consider it in that light, and hope that perhaps this amendment would pass as presented.

SPEAKER ALESEN: Pardon me. Was there a motion to adopt this amendment? Your Speaker apparently went to sleep on that.

A MEMBER: I move we adopt it.

SPEAKER ALESEN: Is there a second?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion? Are you ready for the question?

. . . The question was called for. . . .

SPEAKER ALESEN: All those in favor of adopting the amendment signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: It appearing quite obvious the two-thirds majority is lacking, the amendment fails of adoption.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Amendment number three introduced by Dr. Kirchner of Los Angeles. I might say this was introduced at the instance of the committee, who felt that probably a majority of the members of this House of Delegates had not read the By-Laws, completely at least, and that possibly some of you might not know they provided for two regular sessions of the House of Delegates during the year. The amendment was, therefore, introduced for the purpose of giving you an opportunity to express your desires as to whether we should have them.

As it reads, it will eliminate the regular interim session, and you will have only one regular session plus whatever special sessions might be called.

To comply with the necessity of the occasion there is another change made in the By-Laws by this amendment so that resolutions presented to the committees will be acted upon during the session and not lie on the table until the next session which, if this amendment is adopted, would mean they would lie on the table for a year, which is obviously not desirable.

The purpose of this resolution is to continue the present practice of having only one annual session and special sessions only as called in emergency. After hearing the discussion, there was no question as to the majority opinion favoring a single session, though it was suggested that it might be advisable, in order to facilitate the activities, to consider lengthening the duration of the session and to provide that resolutions to be introduced should be cleared through the component societies. These provisions, of course, are not a part of the amendment as considered. The committee recommends that this amendment do pass.

Mr. Speaker, I move we proceed to vote on this amendment.

SPEAKER ALESEN: Is there a motion to adopt this amendment?

. . . It was moved and seconded that the amendment be adopted. . . .

SPEAKER ALESEN: Is there discussion? Dr. Magoon is recognized.

DR. LESLIE B. MAGOON (Santa Clara County): This is of even greater importance than the last proposed amendment.

Proponents of this amendment, whose effect is to eliminate the provision for semi-annual meetings of the House of Delegates, must believe to some degree in any or all of the following:

1. An interim session is unnecessary.

2. It is too costly to the C.M.A., and/or the component societies.

3. It demands too much in time, money and effort from the individual delegate.

I shall argue those points in reverse order.

It is conceded that an interim session will demand an investment in time, money and effort practically twice that of a single session, unless some allowance is made for a lessening of the pressures that will result from the more leisurely and better organized consideration of business that will result from more frequent meetings. Delegates may well be buying a few more years of pre-coronary existence by spending two more days a year and a few more dollars in their positions as members of this House.

It is conceded, too, that there will be additional expense involved both to the C.M.A. and our counties if semi-annual sessions are held. In the C.M.A., it will be minor; I am informed by the Executive Secretary probably no more than $2,000. The Reference Committee on the budget felt it unnecessary to increase the amount allocated to sessions of the C.M.A. beyond that budgeted for a single session. So far as component societies are concerned, costs will depend on whether or not delegates' expenses are paid.

In my county, Santa Clara, they are paid; and our membership is unanimously of the opinion that that investment has paid an overwhelming return. We go so far as to pay the expenses of all our alternates, whether or not they are called to sit in the House, so that they will not be strangers to this House when they are promoted to delegates. We feel strongly that no society dollar we spend has yielded a better return, and we shall be happy to double the amount for the privilege of semi-annual meetings of the House.

Now, the first point for last consideration: Interim meetings of the House are unnecessary. May I point out that the strongest motive of this House in directing that the By-Laws be revised was a desire to increase the stature of the House of Delegates. It has always been in theory the senior body of the Association, but in practice it had not always so functioned.

It followed almost as cause and effect that if the House were to take a larger part in the conduct of the Association, it would have to meet often enough

to play its role efficiently. It could not drag its feet for a year to make decisions, the need for whose execution was immediate. There is no thought that the House can even approach the flexibility and rapidity of action of the Council, but shortening the interval between meetings to six months would make decisions of the House possible on at least reasonably current problems, and would lessen those circumstances where the House can be only an accomplice after the fact in a fait accompli.

The proposal that except in emergency proposed resolutions lie on the table between sessions would give an opportunity for a delegation to take them home for presentation to its constituents. We believe that that will result in a much greater feeling of participation by the rank and file, and will have a very salutary effect toward controverting the feeling of the average member that this House is a remote body in whose decisions his opinion plays no role.

In our county, at least, there is a great surge of interest in the C.M.A. just before the annual meeting; the rest of the year the Association is mentioned only to be damned. We should like that surge to happen twice a year, and we believe that the interim low point of lack of interest will be not only the shorter but less abysmal; in other words, the cycles will be shorter and the swing less wide.

For these reasons I am in favor of semi-annual sessions, and therefore opposed to this amendment. But I will concede that maybe my county is unique, and that perhaps those of you who feel that effort is greater than the return are right.

In any event, it is a matter of opinion the validity of which can be tested only by trial. I beg of you that you give us that trial. These provisions for an interim session are not frozen in perpetuity; they are in the By-Laws, which can be changed almost overnight, and they will assuredly so be changed if the interim session is irksome and unproductive.

I respectfully solicit a negative vote on this proposed amendment. (Applause.)

SPEAKER ALESEN: Is there further discussion?

. . . The question was called for. . .

SPEAKER ALESEN: Please note an affirmative vote by two-thirds refers to the status quo; that is, a situation in which only one annual session is held. A negative vote merely affirms the present status of the By-Laws in which two annual sessions are provided.

All those in favor of the amendment signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The amendment fails of adoption.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Amendment number four, introduced by J. M. de los Reyes of Los Angeles, is regarding the requirement of the Loyalty Oath. You will note that there are two new sections, one in Chapter V applying to the delegates and alternates, and one to Chapter XIII, a new section applying to the officers and employees of the Association.

Since you have the manuscript before you, it isn't necessary to read it. The discussion of this amendment produced a large attendance at the committee hearing and a prolonged and energetic discussion both pro and con. Since it will undoubtedly be discussed at length on the floor of this House, it is not necessary here to enumerate the many recommendations. The committee was unable to agree unanimously upon a recommendation, two of our members being in favor of the amendment and one opposed. Since the amendment requires a two-thirds vote, we are making, on the basis of this divided opinion, a majority recommendation of do pass.

Mr. Speaker, before proceeding to vote I should like to ask the permission of the floor for Dr. Gibbons.

SPEAKER ALESEN: Dr. Gibbons is recognized.

DR. HENRY GIBBONS III (San Francisco County): I should like to preface my remarks by stating that I have had a very cordial experience with the Reference Committee, and I have enjoyed very much the discussions we have gotten into, and have learned a great deal about procedures of the House that I didn't know before.

It was at the request of Dr. Craig and Dr. Loos that I am making the minority report, with the wish also of my delegation from San Francisco.

It is my belief that this amendment is unecessary and does not belong in the Constitution or By-Laws of the California Medical Association:

(1) Because it will not accomplish the purpose for which it is intended since any communist who so desires will sign the oath without hesitation;

(2) Because it makes office-holding subject to a political test and because it will set a precedent for more dangerous measures;

(3) Because there is no evidence that the California Medical Association has benefited by the existence of the Loyalty Oath during the past year. Indeed, there has developed such varied differences of opinion that there is a threat of a serious split in our ranks;

(4) Because such an oath is compulsory and therefore objectionable to a great many who see in it a threat to their individual liberty and freedom.

(5) Because it is discriminatory against individuals not taking the oath;

(6) Because if a sincere individual refuses to sign the oath it can be said he is among those who are disloyal to the United States. This is a declaration of guilt by association and violates the Bill of Rights of our U. S. Constitution, which states that a man is innocent until proven guilty;

(7) Because I believe in our democratic processes of government and feel as they are practiced in this organization there is no danger of serious communist infiltration in the ranks of our officers.

In conclusion, therefore, I believe if this problem is considered without emotion it will become evident that a Loyalty Oath of this type will do the C.M.A. and its members much more harm that the good its well-intentioned proponents desire. (Applause.)

DR. WILBUR BAILEY: Mr. Speaker, I move for an Executive Session.

SPEAKER ALESEN: A motion has been made for Executive Session. Is there a second?

. . . The motion was seconded. . . .

SPEAKER ALESEN: All those in favor of going into Executive Session please signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The motion is lost.

Is there a motion to adopt this amendment?

DR. LYLE CRAIG: Mr. Speaker, I move we adopt this amendment.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Dr. Cass is recognized.

PRESIDENT DONALD CASS: I believe I had the privilege last year of standing up with this oath in the Council, and I stand up for it again. I think a body as smart and big and aggressive as this group should not be so childish they object to signing an oath which, to the public, means an affirmation of this loyalty.

I sincerely hope you pass this oath, and I ask for a secret ballot on it when you do it. (Applause.)

SPEAKER ALESEN: Dr. Davis is recognized.

DR. DAVIS: I was going to request a secret ballot also.

SPEAKER ALESEN: Dr. de los Reyes.

DR. DE LOS REYES: Mr. Speaker, fellow Americans: I am cognizant of the fact that in proposing this and standing here before you I am going to be severely criticized by many, and even the human qualities of my mother are going to be doubted.

On the other hand, gentlemen, I want to take issue with the minority report. There is nothing in this oath or affirmation that would in any way hamper your belief in the Constitution of the United States, and your political beliefs, or in your religious creed.

Not long ago the County of Los Angeles passed the Loyalty Oath. Today, by coincidence, the Second District Court of Appeals of California affirmed that that Loyalty Oath which, if you read it, is a lot more stringent than what we have asked you to sign, states:

" 'Nothing in the affidavit in the slightest degree affects their political or religious beliefs. No constitutional right is imperiled; no hallowed principle is foresworn; no hazardous or difficult task is assigned.'

"In referring to the role played by county attorneys in fighting for the fulfillment of the terms of the loyalty oath, the justices declared that these officials had every right to demand that the oath be signed.

" 'Their efforts deserve approval, not disapprobation,' the ruling set forth. 'Praise, not execration; eager applause, not muffled drums. Their purpose in exacting the oath is to place about the reliant heart of society renewed confidence in the majesty and power of the American state.' "

It has been said by some of the opponents of this oath or affirmation that freedom is infringed upon. This is no such thing, gentlemen. The only infringement is by some of the members of the university here, members of Cal, and especially the gentleman who was referred to as "Professor X," later known as Dr. Weinberg, who refused at all times to take an oath, and refused before the un-American Committee of the Congress of the United States to state whether he was a communist or not, although he has been prosecuted for atomic spying against his own country.

Dr. Fuchs refused to take an oath of loyalty.

The gentleman by the name of Alger Hiss was convicted, not because he was a traitor to his country, gentlemen, but because he refused to take an oath, because he lied after he took the oath and said he was not a communist and he had not stolen any papers.

That is the purpose of this affirmation resolution, so that we can protect ourselves; so that by following the advice of J. Edgar Hoover we put our own house in order, and we bring about, perhaps, verification of that particular principle that says that America should be the land of the free and should be, under no consideration, dictated or brought into the socialistic or communistic stage.

It has also been said that in certain countries, especially behind the Iron Curtain, particularly Czechoslovakia, that some of those professors were not able to take the oath and those that took the oath to the state later on took the oath to an individual.

We are not asking you to take any oath to any individual. We are asking you to take the oath to the American form of government as prescribed in your Constitution and my Constitution.

The gentleman by the name of Gottwald that was the Vice-Premier, if you want to call it that, of Czechoslovakia, refused to take the oath on the pretext he was a loyal Czechoslovakian, and he said, "I ought not to take the oath. Everybody knows I am a patriot." Then Dr. Benes, the President there, could not fire him because he had not taken the oath. Therefore, he was not a traitor to his country.

Gentlemen, this is no flag-waving. This is not childish patriotism. This comes from the conviction of a man that feels that the greatest boon that can come to any individual on earth is the American citizenship; not like you received it, perhaps, by heritage or happenstance, but one who took the oath of loyalty because he considered this country the greatest country in the world.

As such, I beg of you to pass this oath or affirmation. (Applause.)

DR. J. LAFE LUDWIG (Los Angeles County): Mr. Speaker, members of the House of Delegates: Our United States is a land of great productivity. It is also a land of great salesmanship, to such a degree that individuals from all over the world flock to our shores because we have something in this country; we have the inborn right in this country that they so desire in other countries. They come to this coun-

try of ours; after being here a few years they make their first application for citizenship. Later they receive their final citizenship papers. They appear before a federal judge. A member of their group stands before them, swears them all in as citizens of the United States, and it is a great privilege and pleasure to them.

It is a voluntary thing, something that they ask for, to be given this privilege, to exercise their franchise to vote in this great country of ours.

I wonder if we aren't missing something some place if we don't do a similar thing for our own boys and girls in this country. They go to school every day; you and I did. We stood up in school, we pledged allegiance to the flag. Sort of a little tingle went up our backs because it was something we thought was fine. Our parents told us it was the thing to do. I think maybe it would be a fine example if the members of the California Medical Association would set an example for their children in school by having the intestinal fortitude to stand up and pledge allegiance to this flag of ours. Maybe it would be an example for our children. Maybe it wouldn't. Let's try. (Applause.)

. . . The question was called for. . . .

DR. VERNE GHORMLEY (Fresno County): It is rather presumptuous of me to try to say anything that has not already been said much better by those who preceded me. I had intended to say something, but I found it had already been said. I should apologize to others here who have more extensive knowledge than I do about these things. Probably I can speak very freely because of the limited amount I know about the subject. It doesn't limit me as much in what I would say.

I may have the wrong slant on this thing, but I do feel that there is something here which is very fundamental, although it is elementary. For the last year or two I have been fortunate—maybe unfortunate—enough to have a little insight into some of our programs for national defense, the plans, the hopes, the preparations, and I think quite a few prayers mixed in with it. I am a little alarmed myself when I see the general apathy. People don't realize what could happen.

Unless 90 per cent of those who are in power are wrong, and I hate to think so many people could be wrong, within the next five years we may be fighting for our very lives, nationally, locally, as groups, isolated groups and others. And when you think of a thing like that you don't kick a proposition like that around very lightly. When you think of it in that light, it seems rather trivial that we should quibble about the wording of a few things.

I admit I am alarmed. I become frightened easily. I spent five years in the service in an infantry outfit, and I assure you I can get frightened mighty fast.

But when you think of furnishing medical service for the military, it is rather a simple thing compared with facing a problem of defense for the children, the women, those who are only partially concerned and those who do not choose to be concerned about a problem like this.

I realize some are disturbed by the memories of possibly some early political promiscuity. Getting a person to admit some things probably is very much like approaching a bridegroom and getting him to admit a confession of some early indiscretions.

I think that is of very little importance. The main thing I think that we should be concerned with is what we ourselves now are willing to do, are willing to sacrifice, willing to give up our little picayunish prides or difficulties we have built up in front of us. I think the problem is greater than just fighting over the wording of the thing. The main thing is, what are we going to do? Are we going to help put this country of ours together as we have and help keep it there? I think that we must grow more mature in our thinking along lines of our pride in our country.

As I said, maybe I have the wrong slant on this thing. I don't feel that the medical profession or the doctors, the deans, the teachers, the lawyers, are being discriminated against in asking them to sign this sort of a document. I am proud of the fact. I am proud of the fact we are doctors, that we are enough of leading citizens in this country that people come to us and say, "We know you are willing to stand behind our country. We know we can depend on you," and having tied that down we can go on and meet these other obligations.

Gentlemen, as I said, I feel very strongly about this thing. I don't know how it is worded, but I do feel we, as a medical profession, owe something to our country in the next five years. I thank you. (Applause.)

SPEAKER ALESEN: Dr. Garland is recognized.

DR. L. HENRY GARLAND (San Francisco County): Mr. Speaker and members of the House: It is a privilege to be here and to follow on the stand a member of the third generation of a California medical family. You know and I know that Dr. Henry Gibbons III represents a long line of American physicians who have done their duty by their state and by their profession. I only have the privilege of being an adopted son, but I did have the privilege of serving in the United States Navy during the last war for some three and a half years, and I stand ready to serve again if I am called.

I am not sure that you realized what you were doing when you proposed this compulsory political test. I have been a member of the California Medical Association since 1927. I have tried to fight compulsory health insurance for all those years. I hope to try and fight it until I die. I shall always also try to fight compulsory political tests in a scientific organization.

I agree perfectly with Dr. Lafe Ludwig that a declaration of loyalty to the United States, to the State of California, and to the flag is laudable, and perhaps we should start each of our sessions of the House of Delegates with it. However, this oath does

more. This oath specifies that we are not and have not been a member of an organization declared to be subversive by a political appointee in Washington. That, I think, is hazardous when you look back over the political history of any country.

Will this oath keep communists out of our organization? It is to be doubted. Nobody has claimed that it would. Will it set a precedent for more stringent oaths in years to come? Who knows? It has in other countries. It has in other scientific organizations in other countries. It may in ours.

This oath discriminates, I think, against some members who would like to serve you either as employees or as voluntary members of committees or on your Council, and to no good purpose.

Look what happened at the University of California. I grant you perfectly that the situation is not entirely parallel, but on the other hand, it is not remote. The facts are, amongst the university's employees 133 refused to sign—most of them native-born Americans. Amongst members of the academic center, 24. All were fired with the following results. Now, please note the results. These results took two years to eventuate. The results of your action tonight may take two or ten years to eventuate, but note the results at the University of California:

37 other professors quit in protest.

55 courses were dropped from the curriculum.

47 offers of appointment to the university were rejected because of the oath issue.

19 professional societies put the University of California on a black list.

18 of the university professors who had refused to sign the oath filed suit for reinstatement.

It has been said, apparently with justice, that there is no longer a topnotch theoretical physicist at the University of California—not one of the men whose brains are the root of our scientific discoveries.

It seems to me sincerely that this oath is a compulsory political test. We are a voluntary, scientific organization. This oath is foreign to the democratic foundations of the California Medical Association. It may be the beginning of political regimentation in our Association.

We are told that if you reject this oath tonight the communist press tomorrow morning will have headlines saying, "California doctors reject oath." I would like you to know that the free, democratic press will also have headlines, "California doctors do not allow themselves to be stampeded by short-sighted, although well-intentioned, motivists."

. . . Boos. . . .

DR. GARLAND: Well, that is my sincere belief, and I hope, gentlemen, that you reject this amendment. Thank you very much for your consideration. (Applause.)

SPEAKER ALESEN: Dr. Carson has the floor.

DR. DONALD A. CARSON (San Francisco County): Mr. Speaker, fellow delegates: In speaking against this resolution I wish to confine my remarks to the yardstick on which you are judged fit to represent your constituents in the House of Delegates of this Association. Up until this year delegates have been chosen by ballot in most of the counties of the state, and on the basis of that democratic process have represented various county medical societies down here.

Most of the delegates present tonight did not start practicing last year. Most of you look almost as old as I do, and that means that you have been working and practicing in your communities for several years. During that time your colleagues and your county medical societies have had a good opportunity to judge your character, your ability, and as a result of that you have been elected to sit here as delegates. I am sure you are very proud of that. I know I am.

Now, last year we added something to that. It was felt that the judgment of our colleagues still might not detect the black sheep in the organization, that he might conceal his intents and purposes and pass as an honest man among you and deceive you. So, the Loyalty Oath and the affirmation and the insistence that you had not belonged to any organization declared subversive by the Attorney General of the United States was adopted.

I wonder if that is necessary. If I could be convinced that the taking of an oath or the signing of an affirmation would defeat dangerous characters, keep them from sitting in this House and in the Council of our Association, I think I would go along with you.

However, I am not sure that this is the kind of additional check that you really want. I don't think that I do. I talked very badly at this point last year, but I did say then that the Attorney General of the United States is, of necessity, a political officer, and that as such his views may be, and some of them undoubtedly are, influenced by the politics of the moment.

I ask you what might happen if, say, the pressure on the President to remove Mr. Acheson from office as Secretary of State were to take effect? Would Mr. Truman then appoint him as Attorney General? I wonder what might happen to the list of subversive organizations which is currently published. Perhaps a great many of them might go off. What was evil one day might be harmless the next day. It is a matter of political decision, and we have seen one example of the influence of politics upon justice here on the West Coast in the last five years.

You will recall that in 1945 Mr. Harry Bridges was accused of perjury in stating that he had not been a member of the Communist party. He was brought to trial. It seemed that the prosecution in that trial was rather lackadaisical, not pursued with the full vigor that it was in the second trial. The result was that he was acquitted, and after his acquittal you saw the pictures that I did in the newspapers of his being congratulated by people prominent in the New Deal.

At that time Mr. Bridges and his union were in good standing in the CIO, and the CIO was a valu-

able adjunct to the party in power, to the administration.

Now, with the rising tension against Russia and the other factors Mr. Bridges and his union become unwelcome in the CIO. He lost his appointment as an officer of the international and that was reflected in the attitude of the Department of Justice of the United States.

At his second trial a very able prosecutor was sent out here from the East. We probably had just as good here, but they always look better if they come from New York. He prosecuted this case with great vigor. The case proceeded smoothly and Mr. Bridges was convicted.

It is my personal opinion that he had been guilty as charged all along the line, but it took a change in politics to remove the political defense of this man and change it to one for conviction.

This has not increased my faith in this other yardstick of a list of subversive organizations as published by the Attorney General of the United States.

In closing, I would like to say to Dr. de los Reyes we really have complete confidence in his ancestry, and to Dr. Cass I do not think we are children. (Applause.)

. . . The question was called for. . . .

SPEAKER ALESEN: Let Dr. Alsberge speak. Go ahead, Dr. Alsberge.

DR. E. W. ALSBERGE (Los Angeles County): I apologize for not having a prepared speech tonight. I had hoped not to take the floor, but there have been several, I think, misstatements of fact, I am sure through misunderstanding of the problem.

Number one is the statement that communists will not sign the oath. The facts in the case are these: The head of the Communist Party, William Z. Foster, the head of the National Communist Party, the head of the Communist Party in Los Angeles, Dorothy Healy, have both stated, as have many other leading communists, they will not take the oath; they will go to jail first.

The record before the senatorial and House investigating committees, the records before the courts, bear out that case, with the rare exception and peculiar exceptions like Alger Hiss, whose value is so great he couldn't follow the line without destroying the work of sabotage he was committing. The communists have not and they will not take the oath.

Second is the frequent statement that this is a political test. There are two answers to that. In the first place we agree that the Bill of Rights does guarantee us the freedom of speech. The Constitution also sets up very stringent measures to take care of people who try to destroy them.

As for the political test argument directly, this is not a political faith that we are dealing with. It is a foreign conspiracy, a conspiracy whose sworn purpose is to destroy us and the rest of the free world.

Then the statement, "There is no serious danger of communist infiltration in the officers of the Association," I want to dwell on that just a little bit longer, but just before I do, I want to talk about whether or not the Attorney General's list is binding on us. Last year before Reference Committee No. 3, I insisted with all my strength that if escape clauses be put in this oath for the protection of any indiviual, it would be misleading. If there is any question at all, gentlemen, if we don't like the Attorney General or the Attorney General's list, all we have to do is vote en masse by the House of Delegates as far as those organizations are concerned.

Now, specifically as to the danger of infiltration. I know that these statements have been made sincerely because I don't think the danger is recognized. So, if you will bear with me just a moment, I would like to explain superficially, at least, what we, living in the midst of the second largest concentration of communists in the United States, not only feel but have found is a menace not only to our organization here but all American organizations.

It would take me just a few minutes to trace the origin of a lot of this thinking. In so doing, there is no reflection on anyone.

In Los Angeles around a couple of years ago some doctors who are active members of the Civil Rights Congress and the same for the Arts, Sciences, and Professions Council, banded together to form a committee to fight this specific thing. The name of that committee was the Committee for Defense of Professional Licensure. It had amongst its sponsoring members that notorious joiner of communist front, a man known to you all as Dr. Murray Albowitz. It had also as a sponsor Dr. Thomas Addis. I don't believe I need to elucidate on his record to you gentlemen.

It also had as a speaker Dr. Thomas Perry, the first national president of the Association of Interns and Medical Students whom, I believe, you gentlemen have had a difference of opinion with.

This, gentlemen, was not a casual get-together as we have here with a frank difference of opinion, where everybody could speak their mind and be friends. The line was followed visually. The statements were made that the laws in our country, past and contemplated, were more vicious than anything Hitler had ever passed at the height of his power; that there was a conspiratorial agreement between the Senators in the United States Senate and the Nazi underground to force the rebirth of Naziism in Germany and ultimately the re-Nazification of the world.

I shall not go into the line they chanted any longer. There are several members of this House who are officers of the Association and high officers at the time, and I asked them to go with me and observe. They were duly written up anonymously in the *People's Daily World*, and are present tonight if they care to communicate further on this line.

Now, I shall go hurriedly, gentlemen. Subsequently a group from this Committee on Professional Licensure, which was co-chairmanned by Dr. Tracy Putnam, attempted to organize in Los Angeles County. They did not attempt it; they did it. They joined with a large number of good, loyal Americans; as in all of these cases I cited. Many

didn't take the care to look at the document they were signing and sponsoring; not half the care they would take in writing a prescription in their office, but much more is at stake, in spite of the fact that widest publicity was given to this, including meetings, circularization of written material.

The point I want to make is this, gentlemen: They drew 20 per cent of the vote of the Association.

Now, traveling with Dr. Tracy Putnam from the co-chairmanship of this previously mentioned committee of defense of professional licensure, we arrive at the positions against the Burns Bill, the first signature there. He had a number of friends in that group.

Tracing it from that point without wasting any more of your time, gentlemen, we go to a group from that organization joining with a similar group from the lawyers. Now, let's understand it correctly, gentlemen. There are not in those groups a preponderance of communists or communist sympathizers, and anybody who says so doesn't know the first thing about the situation. But I wish to leave it to your judgment, gentlemen, if somewhere along the line there hasn't been a great deal of influence of judgment on this situation, and it is this influencing of judgment by individuals with motives that I not only can question but condemn, that I want to bring out, gentlemen.

We heard an excellent speech from Mr. Bender, Dr. Bender's son, on this floor about the medical schools turning out students who were socialized before they even hit the first day of practice. Is it any wonder, gentlemen, with some of these men I have named on the faculties of our medical schools? Their attempt to come into the Association will be followed by their attempt to come into this House as alternates and delegates. There is no question about it. I fear that.

This oath will do nothing but make it possible to expel them from the House if they wish to pervert this House; no more, no less.

I, too, had military service with the infantry, if that is necessary to qualify here as a speaker. I don't believe it is, but in that infantry service I was impressed with an example that I think is quite analogous, gentlemen.

That is the lone infantry soldier standing then as he stands today in Korea, standing guard at a lonely outpost. Somebody approaches. In essence his challenge, gentlemen, is "Halt, who goes there? Advance to be recognized. Friend or foe?" Gentlemen, is that too much to ask of us on our home front?

I urge, from a deep knowledge of the situation, the passage of this resolution. (Applause.)

. . . The question was called for. . . .

SPEAKER ALESEN: Let's be orderly about this. If you want to stop debate, move the previous question.

A MEMBER: I move the previous question.

. . . The motion was seconded and put to a vote. . . .

SPEAKER ALESEN: The previous question is lost. Dr. Caldwell, proceed to debate.

DR. GEORGE W. CALDWELL: Mr. Speaker, members of the House of Delegates: I promise to take only one minute. You may time me.

I wish to say this first: I think the speakers that have preceded me that are opposed to this oath are honest and sincere in their beliefs, and I believe they are also good citizens. However, I am for this oath. I think we should vote to sign it for several reasons: The eyes of the people of California are upon this House tonight, even of the entire United States. As doctors we are leaders in the State of California in our profession, and we also are respected by the public. Our action here will mean a great deal in the public press if we do not pass this oath.

I would like to correct the one error that I consider was made by one of the previous speakers. He said that in years to come more stringent oaths would be passed. Well, if they are they will be passed by the members of this House, and I think we are all pretty level-headed. I don't believe we are going to pass any political tests. Let us not go home to our families, to our friends, and have to face our patients and say we as a House representing the doctors of California refuse to vote to sign this oath. (Applause.)

SPEAKER ALESEN: Dr. Dwight Wilbur has the floor.

DR. DWIGHT WILBUR: Mr. Speaker, members of the House of Delegates: I have been very much interested in the reaction of doctors and lay peoples throughout the state to this oath, and I think one can readily see such persons fall into three groups.

First, there are those who are rabidly in favor of such an oath. Secondly, there are those who are rabidly against such an oath. Then, there is a third group that can't figure out why anybody makes any fuss about it at all.

I think those of us in this House are divided in that way, and I doubt if anything anybody has said has altered a single opinion in this House because it is on an emotional level.

In order to square my conscience, because I agreed to do so, I would like to say just a few words about it. It is said in our Constitution that the purposes of this Association are to promote the science of art and medicine, the protection of public health, and the betterment of the medical profession; to promote similar interests of its component societies and unite with similar organizations of other states and territories of the United States to form the American Medical Association.

I think before we add to the Constitution any By-Law or in any way amend it, we should think of two things. First, what good it does. Does it serve the purposes for which we have organized this Association? Secondly, does it do any harm?

So far as this particular Loyalty Oath is concerned, I can think of no good that it has done to this organization, nor to any other—certainly to no political organization which has required it.

While there has been some variance of opinion whether communists would or would not take the oath, this is a difference of opinion, and I happen to be one who believes it would make no difference to a communist. He is a liar fundamentally.

Now, will it do harm? All we can do is go on the basis of experience. In this organization it has done harm—as witness debate this evening. It has done harm also to us during this past year, the details of which I don't have time to emphasize tonight.

But we can find a very great lesson from the harm it has done to the University of California. I am sure that in the lifetime of every individual in this room the University of California will never again occupy the position which it did prior to the requirement of the Loyalty Oath.

It has split the 20-odd ablest men in the state who are members of the Board of Regents right in half —exactly in half—and it has caused changes which Dr. Garland has read to you. Those are harmful, and there is reason to believe that harm also will come to our Association, although, of course, not as great harm.

So, personally I am very much opposed to the oath for those reasons.

Finally, we live in a democratic country, and this is a democratic organization. Compulsion has no part in democracy, and this oath is compulsory, and on that ground alone, no matter what the subject of it, it should not be accepted.

Now, I understand the viewpoint of those who feel that this oath should be passed. I also suggest that those of you who feel that way respect the opinions of those of us who feel differently, and if you do, then I do not see how you can ask that such an oath be required. (Applause.)

DR. ROBERT LEO STERN: Mr. Speaker, members of the House of Delegates: I speak to you not only as an individual and as a delegate to this House, but I have been asked to speak to you as president of a rather unique organization, the Medical, Dental, Nursing Veterans Association of Los Angeles County. These men have a right to be heard on this subject particularly, not only by the inherent right which we all have as citizens, but by the right of investment which most of you men in this House, I presume, also have; by the right of their investment of years, many years of their professional lives in the service of their country. That is a very basic investment, five years of a man's professional life gives him a strong right to a strong opinion.

The Medical, Dental, Nursing Veterans Association has asked me to ask you to vote favorably. It feels it is fitting and proper that this bill be passed.

Loyalty Oaths are nothing new. They are nothing new to me or to any of you. My grandfather in 1860 took a Loyalty Oath to become a citizen. My father took a Loyalty Oath when he entered the school, when he became an officer of many organizations, and I started taking Loyalty Oaths at the age of six in kindergarten, and took them every day.

Again, as an individual and delegate and president of the Medical, Dental, Nursing Veterans Association of Los Angeles County, I ask a favorable vote on this amendment. (Applause.)

SPEAKER ALESEN: Dr. Askey is recognized.

DR. E. VINCENT ASKEY (Los Angeles County): Mr. Speaker, ladies and gentlemen of the House: I want to just call one or two points to your attention.

The first is that I am certain that the majority of the members of this House desire no officer, no delegate, no member of our Association to be wrongfully denied a seat in this House, whether he takes the oath or doesn't take the oath. And if I may call your attention to the last sentence in the Oath of Loyalty, it says this: "Any person refused a seat by the action of the Credentials Committee because he doesn't sign the oath shall have the right to appeal to the House, and by a majority vote the House may override the Credentials Committee and seat such person as a delegate."

That means to me, gentlemen, that there are undoubtedly many people who are sitting in the audience today who have been misled. They may have belonged to an organization which they cannot say they did not belong to, but they regret it terribly. They hope and they wish they could sign that oath.

I think everyone here would like to sign it, but some of them fear there will be a stigma attached to them.

Now, we have taken care that such a man as that has only to tell his story to you. You can say, "Joe, you are all right. You made a mistake, but thank God you know what is right."

Now, ladies and gentlemen, it is an important thing, and I deeply regret to see so many of my best friends, Dwight Wilbur, Henry Garland, Henry Gibbons, and the rest of these men who stand as outstanding patriots of my country, the fact that they are misled does not make me think any less of them. I am sorry for them, sincerely. (Applause.)

I am going to say another thing about my friend, Henry Garland. He says that all the University of California did was to get rid of some good physiologists. They also were teaching communism there, as Dr. Chief Bender's boy told you. If we get rid of some teachers that are communists, I don't care whether they are good physiologists or anything else, they have no right to be there.

. . . There were shouts of "Hooray." . . .

The American Medical Association, of which you stand as an integral part, has led against socialism. Why shouldn't we lead in patriotism? They say it is compulsory. It isn't compulsory to sign it as I showed you. If you don't want to sign it, appeal and give us your reasons and we will stand with you if you are right.

I was on the Board of Education of this city for six years. It was my privilege every meeting of that Board to get up and swear allegiance to the flag and loyalty to my country. I did it last week; why not do it today? We know who you are. Because I was proud, too.

Somebody has said that the Attorney General, a political appointee, is the officer that stated these were unpatriotic organizations. If an Attorney General, an admitted political officer, advocates this and calls other organizations subversive, isn't it a welcome change, and indicative that perhaps yet there is hope for the United States and not all of our political officials are misled? (Applause.)

Ladies and gentlemen, I am not going to say much more. You don't need it. I get the sense of this thing that if I have to take the oath every 10 minutes I will take it and be proud of it, and I thank God that there are enough people that believe as I do. (Applause.)

SPEAKER ALESEN: Dr. Kirchner.

DR. ARTHUR A. KIRCHNER (Los Angeles County): Most of you here embrace Christianity. For almost 2,000 years we have reaffirmed our loyalty to the Christ by the participation in communion services of our respective Christian churches, and I am sure if any of you had to swear you would be loyal, you would not hesitate one moment.

Tonight we are asking that you affirm your loyalty to the greatest material thing that you have; that is the State of California and the whole United States. That is all I have to say. (Applause.)

SPEAKER ALESEN: Dr. Ruddock from Los Angeles is recognized.

DR. JOHN C. RUDDOCK (Los Angeles County): Mr. Speaker, members of the House of Delegates: Today we are at war. Although that war is not declared, we are at war. We are fighting for our existence. We are fighting for our way of life. We are fighting to continue this form of government in this nation in the manner in which we are used to and which we like.

Who are are our foes? Our foes are communists and our boys are dying for this one particular principle which we are trying to affirm tonight.

We are merely asking in this resolution or amendment that we affirm that we are not communists or that we belong or have any association with any political party which has been declared as subversive.

Our subversive foes today are our enemies. If this were a declared war and we found any communists, we would intern them. We would put a fence around them and we would isolate them if this war were a declared one.

It is not. It is a war of principle tonight, and some of our boys are dying for it. I think we are quibbling over something which I believe all of us should affirm without any further quibbling.

I am an American citizen, and I am awfully glad of it, and I would take this oath or any other way it might be worded in any shape or form as often as I could take it, and if I ran out of breath I would have somebody else do it for me. But I urge you tonight, gentlemen, to pass this amendment and I would urge that the vote be public and not secret. (Applause.)

A MEMBER: Mr. Chairman, I move the previous question, please.

. . . The motion was seconded. . . .

SPEAKER ALESEN: This is a privileged motion. All those in favor of the previous question signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: It is unanimous. Debate stops. We now recur to a vote on the pending question, the adoption of the proposed amendment to the By-Laws. How will you vote?

. . . There were calls of acclamation. . . .

SPEAKER ALESEN: Are you satisfied with a standing vote?

. . . There were calls of yes. . . .

DR. THOMPSON: Mr. Speaker, may I request a secret ballot?

SPEAKER ALESEN: A secret ballot has been requested.

. . . There were calls of no. . . .

SPEAKER ALESEN: To have a secret ballot requires a majority vote. Does someone wish to move for a secret ballot to settle this once and for all?

DR. THOMPSON: I move for a secret ballot.

. . . The motion was seconded. . . .

SPEAKER ALESEN: It has been moved and seconded we ballot secretly. All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was lost. . . .

SPEAKER ALESEN: Do you now wish to vote by standing?

. . . There were calls of yes. . . .

SPEAKER ALESEN: All those in favor of the amendment as proposed will signify by standing.

. . . A standing vote was taken. . .

SPEAKER ALESEN: There is no doubt in the mind of the Speaker that the amendment has been adopted by more than a two-thirds majority. We therefore declare it has been adopted.

. . . There were shouts of "Hooray" and applause. . . .

DR. GEORGE I. DAWSON (Napa County): Mr. Speaker, is there some way we can make this unanimous?

SPEAKER ALESEN: No, sir. Dr. Craig, proceed.

DR. LYLE CRAIG: Mr. Speaker and members of the House: I think you may realize now what I meant by saying it aroused considerable discussion in the committee meeting.

Amendment No. 5 was introduced by John W. Green for the Council. This resolution is to amend Chapter VII, Section 2 of the By-Laws as printed on page 44 of the Annual Reports Bulletin.

WHEREAS, It would appear inappropriate that a member of the Council always be a member of a Standing Committee; now, therefore, be it

Resolved, That the word "shall" in line three of the first sentence be changed to "may," and the first

sentence shall thereafter read as follows: "Unless otherwise provided in these By-Laws, each of the Standing Committees (except House of Delegates Reference Committees) may consist of one member of the Council and two other members."

This would probably have been included by the committee in their original changes in the By-Laws, but it was, unfortunately, omitted.

The committee recommends that this amendment do pass.

Mr. Speaker, I move that we proceed to vote upon this amendment.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion? All in favor of this amendment signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Proceed, Dr. Craig.

DR. LYLE CRAIG: Amendment No. 6 introduced by Dr. Leon Parker of San Francisco, regarding the oath of allegiance to the flag.

The committee feels that the passage of the amendment to the By-Laws requiring a Loyalty Oath makes this amendment somewhat superfluous. We therefore recommend that it do not pass, if it is not withdrawn.

SPEAKER ALESEN: How do you wish to act on this amendment?

DR. LEON PARKER (San Francisco County): Mr. Speaker, I withdraw my motion.

SPEAKER ALESEN: The motion is withdrawn. Proceed, Dr. Craig.

DR. LYLE CRAIG: That concludes the consideration of the proposed amendments to the By-Laws.

The next order of business is the consideration of the committee's report on the resolutions introduced at the session more than 24 hours ago.

Resolution No. 1 was introduced by the representative from Humboldt County, and refers to the payment by California Physicians' Service and insurance carriers for x-ray and laboratory service. Since you have the manuscript in your hands, it will not be necessary to read it.

The committee has changed the final paragraph to read:

Resolved, That the California Medical Association go on record as recommending that all prepaid health insurance companies give equal coverage for x-ray and laboratory services, whether performed in or out of the hospital, in order to eliminate this growing threat for unnecessarily increased hospitalization. We also instruct the office of the California Medical Association to supply to California Physicians' Service, the Blue Cross and all private insurance companies offering either service or indemnity policies in California, a copy of this resolution.

The committee recommends that this amended resolution do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered. Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 2 was introduced by Dr. Justin J. Stein of Los Angeles, and refers to Armed Forces Day on May 19.

The committee has made no change in this resolution and recommends do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is adopted.

DR. LYLE CRAIG: Resolution No. 3 was presented by Dr. Ralph Teall of Sacramento County, and is printed on page three. It refers to the violation of the medical Code of Ethics by the salaried employment of certain types of physicians by hospitals.

The committee has changed the final paragraph to read:

"*Resolved*, By the California Medical Association that each component society be advised to reexamine the practices of its own members in this regard by assigning this important problem to a committee for study and action, so that appropriate measures may be taken to eliminate any violation of this ethical principle."

We recommend that this amended resolution do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. LYLE CRAIG: Resolution No. 4 was introduced by Dr. Donald A. Carson of San Francisco and refers to the new fee schedule of California Physicians' Service.

Inasmuch as the California Physicians' Service has agreed to withdraw this fee schedule and to continue a committee to formulate a more satisfactory one, it appears to the committee that this resolution is unnecessary. We, therefore, recommend that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Favorable action on this motion rejects the resolution. Is there any discussion?

All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The motion is adopted. The resolution is rejected.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 5 is also printed on page three and was also introduced by Dr. Donald A. Carson of San Francisco. It refers to instructing the legal counsel to direct an educational campaign on restraint of trade and anti-trust laws.

After considerable discussion with legal counsel, we have decided that this subject is so technical and so many points are controversial, depending on unpredictable legal decisions, that many pitfalls would be encountered in attempting to give to the profession any adequate knowledge of the subject in the time or space which could be allotted to the attempt. Therefore, the committee recommends that the resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there discussion? The adoption of the report rejects the resolution. All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The report is adopted.

DR. LYLE CRAIG: Resolution No. 6, introduced by Dr. Donald Carson of San Francisco, is printed on page four of your mimeographed copies, and refers to the results of a questionnaire to doctors on the various matters of C.P.S.

We feel that the purpose of this resolution has been partly achieved by its mere presentation to the delegates and the advisability of instructing the Council to poll the entire membership in a similar manner is very questionable. We have, therefore, changed the last paragraph of the resolution to read:

Resolved, That it be suggested to the Council of the California Medical Association that they take cognizance of the opinions that are expressed by the profession.

Your committee recommends that the amended resolution do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 7 was an amendment to the By-Laws which has already been considered under amendments and has been rejected.

Resolution No. 8, printed on page five, was introduced by Albert G. Miller of San Mateo County, and refers to the cost accounting survey of physicians' professional services at a cost not to exceed $250,000.

It is the feeling of the committee that while such a survey might produce evidence of value, yet the experience of the Association has been that such procedures are apt to be inaccurate and the conclusions therefrom so controversial as to render them of such slight value as not to justify them nor their cost.

We, therefore, recommend that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The report is adopted.

DR. STANLEY TRUMAN (Alameda-Contra Costa County): Mr. Speaker, regarding Resolution No. 7, just because the House rejected it as an amendment does not mean they necessarily reject it as a resolution, does it?

DR. LYLE CRAIG: It was presented in the form of a resolution as an amendment, and was referred to us as an amendment.

DR. STANLEY TRUMAN (Alameda-Contra Costa County): I see.

SPEAKER ALESEN: Is that satisfactory?

DR. STANLEY TRUMAN (Alameda-Contra Costa County): Yes. Thank you.

SPEAKER ALESEN: Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 9 was introduced by G. Wendell Olson of Orange County, and is printed on page five. It refers to the requirement of the Department of Rehabilitation of the State Department of Education for the employment of surgeons licensed by the American Specialty Boards.

In the interest of accuracy the first paragraph has been changed to read the "American Specialty Boards" instead of the "American Board of Surgery." We have further changed the second paragraph to read:

". . . and whereas the Journal of the American Medical Association well expresses the policy of all such boards on pages 149 and 179 of Volume 144, Number Two, September 9, 1950, in the following statement."

The remainder of the resolution is unchanged. The committee recommends that this amended resolution do pass.

Mr. Speaker, I move the adoption of this section of the report.

DR. BURT DAVIS (Santa Clara County): I should like to amend this resolution by adding the words, "and the California State Department of Public Health in its utilization of crippled children's funds." Inserting those words immediately following the words, "California Department of Education," in the second line of the resolution.

SPEAKER ALESEN: Is there a second to this proposed amendment?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Are you clear about this proposed amendment?

. . . There were calls of no. . . .

SPEAKER ALESEN: Read it again, Dr. Davis. Tell them why.

DR. BURT DAVIS (Santa Clara County): The reason I am offering this amendment is that I note in the following amendments referring to the utilization of funds for the Crippled Children's Services that the recommendation of the committee is that one of those resolutions do not pass. And the reason given by the committee which I am anticipating at this point, is that there is no effective method of conveying this information to the department.

Therefore, since the spirit of my resolution has been already expressed in this resolution from Orange County with regard to the same problem, the identical problem, in the instance of rehabilitation, I feel that the same problem occurring in both departments can very well be handled by the same resolution if the resolution is allowed to encompass this wider scope.

Therefore, I should like to see this resolution read,

"*Resolved*, That this Association, through its proper representative, request the Department of Rehabilitation of the California State Department of Education and the California State Department of Public Health in its utilization of Crippled Children's funds to desist from its expressed discriminatory policy and instruct them to obtain a list of qualified surgeons and specialists in related surgical specialties from the local county medical association in that area wherein such rehabilitative and corrective surgery is authorized at the expense of the State of California."

SPEAKER ALESEN: This amendment has been moved and seconded. Is there any discussion? Are you ready to vote on the amendment? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The amendment is adopted.

Do you wish to discuss the resolution as amended? The vote is upon the resolution as amended. All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: The resolution as amended is adopted.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 10 was referred to Reference Committee No. 1 and has already been considered.

Resolution No. 11, introduced by Burt Davis of Santa Clara, refers to the objectionable requirement of notarizing narcotic inventories.

I believe that is the only one that has to be notarized now. I discussed this with some of the delegates and I would like to say that they do not seriously object to this but rather they seem to agree with the committee.

While we share with the author of this resolution the irritation of this practice, we feel that we should not further burden the California delegation to the House of Delegates to the American Medical Association, whose time might be more profitably spent on activities of greater scope. The committee therefore recommends that the resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Dr. Davis wishes to speak.

DR. BURT DAVIS (Santa Clara County): I am inclined to agree with the Resolution Committee. However, I would like to make one statement and that is that any time it is within our power to instruct a governmental body to remove some of the red tape that it has foisted upon the rest of us, I am in favor of it.

SPEAKER ALESEN: Dr. Bailey.

DR. WILBUR BAILEY: Mr. Speaker, I think these next two resolutions by Dr. Davis are perfectly delightful; the next one especially about amortizing taxes. I like them.

Now, as to this business of notarizing narcotic inventories, it just shows how, if you let some governmental clerk get ahead of you in Washington, you eventually get used to being insulted and pushed around. It means that 17,000 doctors in the state every year have to go and pay a notary fee because somebody somewhere wrote down that the thing should be notarized. It is a perfect nuisance and inexcusable.

As a member of the Board of Medical Examiners for some years, and I think there are some other members here in the room who will bear me out, I have never seen this do any good yet. We have had a number of doctors for narcotics charges, not keeping proper records, perhaps selling narcotics where they shouldn't, but never has this particular practice come up and been used in evidence; but it is simply a useless irritation, and I hope you instruct our delegates to do everything they can to abolish it. I suspect if somebody telephoned somebody in Washington it wouldn't appear after the next printing.

SPEAKER ALESEN: Is there further discussion? The vote is on the adoption of the report. If you adopt the report you reject the resolution. All those in favor of the report signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: You have adopted the resolution.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 12 was introduced by Dr. Burt Davis of Santa Clara. It refers to the amortization of the cost of medical education for tax purposes.

This, too, the committee feels would be a desirable achievement if possible, but the precedents are so well established and the decisions of the Internal Revenue Department so universally against such amortization that the committee feels that the California delegates to the American Medical Association would be given an impossible task, which is not advisable. The committee, therefore, recommends that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor of the report, the adoption of which rejects the resolution, signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The resolution is adopted.

DR. LYLE CRAIG: Resolution No. 13 was introduced by Dr. Davis of Santa Clara, and refers to the petitioning for changes in the administrative policy regarding the professional requirements for the treatment of crippled children.

The sense of this resolution has already been incorporated in the previous resolution by action of the House. However, the committee feels that the resolution is defective in that it does not contain sufficient standards by which the lay administrators could be guided in referring such cases. We feel that some standard of clarification is justified and that the matter should be given further study before any action is taken.

The committee therefore recommends that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

DR. BURT DAVIS (Santa Clara County): Mr. Speaker, in view of the previous action, I would like to withdraw this resolution.

SPEAKER ALESEN: If the House has no objection, Dr. Davis withdraws his resolution. Hearing none, the Speaker allows him to withdraw it.

DR. LYLE CRAIG: Resolution No. 14, introduced by Dr. Burt Davis of Santa Clara, refers to the relatively insignificant federal appropriation under the California Crippled Children's Act.

The committee is in sympathy with the ideas expressed by this resolution and, therefore, recommends that it do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: It is adopted.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 15, introduced by Dr. Davis, refers to the requirement for compulsory annual contribution by doctors to medical schools.

You are familiar with that one which says that a doctor should prove that he has paid $10 to support a medical school before he can get a receipt for his dues, or something to that effect.

We recognize fully the great need for funds but inasmuch as the American Medical Association is launching an extensive campaign on this same subject, we feel that no action such as that specified in the resolution should be taken at this time.

The committee therefore recommends that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The report is adopted.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 16, introduced by Dr. Davis, refers to the establishment of a fund for aid to medical schools.

The committee feels that this provision is to the best interest of both the medical schools and the profession, and recommends that it do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: It is adopted.

DR. LYLE CRAIG: Resolution No. 17, introduced by Dr. Davis of Santa Clara, refers to the free distribution of CALIFORNIA MEDICINE to students.

For the purpose of clarity, the resolution has been amended as follows:

Resolved, That the House of Delegates of the California Medical Association desires that, if possible, arrangements be made to send a copy of CALIFORNIA MEDICINE to each student registered in the medical schools of the State of California.

The committee feels that there are some problems involved in the effective carrying out of this resolution and that the Council should not be ordered to carry out what might be impossible of accomplishment. However, the goal of the resolution is so desirable that we recommend that the amended resolution do pass.

The original resolution read "to each student in California," which would include everybody from kindergarten on up. That was obviously not the intention of the resolution.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion?

DR. BURT DAVIS (Santa Clara County): Is that contrary to what is written here?

DR. LYLE CRAIG: It is contrary to what is written here because it would create an impossible situation.

DR. BURT DAVIS (Santa Clara County): In view of the previous action I request to withdraw this.

SPEAKER ALESEN: Does the House object to Dr. Davis withdrawing this resolution? Hearing no objection, the Speaker declares the resolution withdrawn.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 18, introduced by Dr. Leon Parker of San Francisco, refers to the establishment of a board of approval for voluntary health insurance.

The committee has studied this worthy resolution, even to the extent of attempting to rewrite it in a more compact form achieving its intent. However, after this study our final conclusion is that for the following reasons we feel it unwise:

1. It might place the Association in jeopardy to the extent of potential legal action by organizations not satisfied with our rulings.

2. The insurance carriers are regulated by the Insurance Commissioner of the state, and are required by law to offer free choice of physicians and establish adequate cash reserves.

3. The very considerable expense of setting up the machinery provided for in this resolution is not justified in consideration of the slight benefit derived by the Association.

4. The Council on Medical Service of the American Medical Association already approves or disapproves medical groups offering prepaid health insurance throughout the nation, including California.

Therefore, the committee advises that this resolution do not pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? Dr. Parker!

DR. LEON PARKER (San Francisco County): Mr. Speaker, ladies and gentlemen: I don't wish to take great issue with the committee, but they have told us they studied this at length and then did not come to a conclusion that they wish to offer us a substitute resolution. Inasmuch as this deals with this part of our insurance not covered particularly by our own plans, and I believe the portion of that in California is about six million people covered, that is, not under physician plans, and about one million under our plan, this would give us some method of encouraging good insurance to be written.

I would, therefore, offer this substitute resolution:

"*Be It Resolved,* That the House of Delegates of the California Medical Association instruct the Council of the California Medical Association to institute a study into classifying and improving voluntary health insurance."

SPEAKER ALESEN: Is there a second to this proposed amendment?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion on this proposed amendment?

DR. LYLE CRAIG: It is an amendment by substitution, isn't it?

DR. STANLEY TRUMAN (Alameda-Contra Costa County): Is this amendment by substitution? It is out of order at this time.

SPEAKER ALESEN: Elaborate your point, please, Dr. Truman. In what way is it out of order? We are voting on it.

DR. STANLEY TRUMAN (Alameda-Contra Costa County): Is he offering an amendment to this amendment?

SPEAKER ALESEN: He is offering to amend the committee's report by substituting an entirely new proposal.

DR. STANLEY TRUMAN (Alameda-Contra Costa County): He didn't so state.

SPEAKER ALESEN: That is the way the chair interprets it, Dr. Truman. Are you satisfied?

DR. STANLEY TRUMAN (Alameda-Contra Costa County): Yes.

SPEAKER ALESEN: Is there discussion on this proposed amendment? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The amendment is lost.

We now recur to the original amendment of the committee, which recommends that the resolution be rejected. If you adopt the committee's report you reject the resolution. Do you want discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The committee's report is adopted. The resolution is rejected.

Proceed, Dr. Craig.

DR. LYLE CRAIG: Resolution No. 19, introduced by Wilbur Bailey of Los Angeles, refers to the establishment of a state board of psychologists.

This resolution opposes the formation of such a board and the committee recommends that it do pass.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion?

DR. WILBUR BAILEY (Los Angeles County): Mr. Speaker, in the interest of conserving time, I didn't discuss a similar resolution last year, which was a mistake because I have had psychologists in my hair ever since. That is a bad thing to have in your hair. I think I would like to tell you how this all came about.

We had some 10 minor changes in the Board of Medical Examiners asking the Legislature for several things. A "doctor" has a sign or an advertisement saying "M.D.," and that is an offense. If he has a card or letterhead saying "M.D." that is all right. So, we fixed that up so that isn't all right either. We also fixed it up so that diagnosis is more

clearly determined. We wanted, of course, to pick up the people who take your blood pressure on the street corner and make a charge and tell you what they think is wrong with you. The chiropractic legal advisor said he didn't object to it much, although some of their chiropractic brothers did follow such practices, but the psychologists were dreadfully excited about it.

Then there was another one increasing the penalties. Maybe you heard of the New Yorker system and maybe you read of Brinkley in the papers. They called him in and fined him $100. He said that didn't hurt because he was making $2,000 a day at the time. We thought maybe we could elevate their sights on the fines to keep up with inflationary practices, and that struck trouble, too, also with the psychologists. We are terribly afraid they will think this aptitude test is dangerous, but after talking to them I think many of them will come to our way of thinking. They are divided into three groups, the ones who have always worked with doctors, who have time to sit down and talk to patients by the hour and do what the doctor of medicine tells them to do, and the second are an academic group that has in the back of its mind the feeling that maybe if we get a licensing board and the Board of Medical Examiners doesn't bother us too much we can get a few more students in our department; and the third group which starts on dianetics and winds up at lower levels.

Now, what we propose to do here is to not only be against forming a State Board of Psychologists, which I think is not very likely to happen this session, but to go further in a positive way and get them registered as the physiotherapists are registered, or I hope they will be by the time the session is over, under the Board of Medical Examiners, so those who have had a real medical education and are trying hard to be ethical, we will have a line on.

By the same token, they want to be registered with the California Medical Association, the ones who are honest and doing the best they can. That is quite an about-face.

I think it was worth speaking to you. I thought you would like to know for your information so when the subject of psychologists comes up next time you won't have any trouble with them.

SPEAKER ALESEN: Is there any further discussion? All those in favor of the committee's report signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The report is adopted.

Dr. Craig!

DR. LYLE CRAIG: Resolution No. 20, introduced by Dr. L. C. Burwell of Los Angeles, refers to the requirement by adoption agencies of specialist care of adopted babies during the probationary period.

Your committee agrees with the resolution and feels that the requirement is unnecessary and undesirable. We have made no change in the resolution and recommend that it do pass.

I might mention we were told of cases in which the family doctor who had taken care of the family for years was refused by the agency the privilege of caring for the adopted baby, although he might be the advisor of the other members of the family, including the children.

Mr. Speaker, I move the adoption of this section of the report.

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

DR. LYLE CRAIG: Mr. Speaker, I move the adoption of the report of Reference Committee No. 3 as a whole as amended.

. . . The motion was seconded. . . .

SPEAKER ALESEN: All those in favor signify by saying, "Aye."

. . . The motion was put to a vote and it was carried. . . .

SPEAKER ALESEN: It is so ordered.

That is an excellent job, Dr. Craig. (Applause.)

DR. LYLE CRAIG: I should again like to thank the members of the committee, and also express my thanks for the courtesy of those numerous members of the House who appeared before us. We had a good time.

SPEAKER ALESEN: Reference Committee No. 4, Chairman Dr. Sampson. No report.

Mr. Secretary, is there any unfinished business on your desk?

DR. STANLEY KNEESHAW (Santa Clara County): I would like the privilege at this time to introduce a resolution to move that a vote of thanks be given to the Little Giant from the San Joaquin Valley, Frank Doughty, for his excellent work as the head of C.P.S. this year. (Applause.)

SPEAKER ALESEN: That round of applause, Dr. Kneeshaw, indicates, I think, the passage is obvious.

Mr. Secretary, are there any new items of business on your desk?

DR. J. NORMAN O'NEILL (Los Angeles County): Mr. Speaker, members of the House of Delegates: I just want to propose a vote of thanks to Dr. Arthur Smith, who has done a tremendous job, as you probably all know, in formulating the motion picture program. This is something which in the heat of all these discussions might well be forgotten. Dr. Smith has spent seven months of hard work in formulating this very excellent program, which consisted of 92 motion picture films requiring 27 hours of running time.

In addition to that he has made several long-distance telephone calls and sent telegrams and written letters no end. He has received very favorable commendation from both the American College of Surgeons and the American Medical Association, and he has even taken the time to run the films at night, and I believe that is one tremendous contri-

bution to the success of this meeting that should not be overlooked. Thank you. (Applause.)

SPEAKER ALESEN: Dr. Ghormley, will you please escort the new Vice-Speaker, Dr. Randel, to the platform.

Now, Mr. Secretary, will you please proceed with the new business?

SECRETARY DANIELS: Mr. Speaker, there is only one item of new business. That concerns the San Francisco Medical Society having a new charter issued to them since they have changed their name from San Francisco County Medical Society to the San Francisco Medical Society. We request authorization from the House of Delegates for the issuance of the new charter.

SPEAKER ALESEN: Do I hear a second?

. . . The motion was seconded. . . .

SPEAKER ALESEN: Is there any discussion? All those in favor signify by saying, "Aye."

. . . The motion was put to a vote. . . .

SPEAKER ALESEN: The two-thirds majority required by such an action is quite obvious. The motion is passed.

Is there other new business? If not, we will present your President, Dr. Donald Cass.

PRESIDENT DONALD CASS (Los Angeles County): It is with a great deal of pleasure that I introduce to you your new President. This funny-looking fellow and I have been many miles together, Dr. H. Gordon MacLean. (Standing applause.)

PRESIDENT MACLEAN: Mr. Speaker, members of the House: Thank you very, very much.

I now take great pleasure in introducing our President-Elect, Dr. Lewis Alesen. (Standing applause.)

PRESIDENT-ELECT ALESEN: I am not going to make a speech, but some time I would like to take about three hours and go into the biological origin of society with you. I do want to say to you that the happiest times of my life have been spent with a gavel in my hand presiding over the California Medical Association House of Delegates. When I drop this gavel it is with a feeling of nostalgia. I am just being kicked upstairs. I am sorry, but thank you, nevertheless. (Applause.)

PRESIDENT MACLEAN: I now have the pleasure to introduce our new Speaker of the House, Dr. Charnock. (Applause.)

SPEAKER CHARNOCK: I deeply appreciate the support of the House of Delegates, and will do my best to conduct the meetings as expeditiously as has been done by my distinguished predecessors. (Applause.)

PRESIDENT MACLEAN: I now have the pleasure of introducing our new Vice-Speaker, Dr. Randel. (Applause.)

DR. HENRY RANDEL: President MacLean, members of the House: We are deeply grateful. When I say "we" I mean it collectively. We are here to do your bidding from the Oregon border to Ensenada. Thank you very much. (Applause.)

PRESIDENT MACLEAN: I also wish to announce that Dr. Cass, our retiring President, is now the new President of C.P.S. (Applause.)

SPEAKER ALESEN: Now, Dr. Kneeshaw, will you please step forward and perform a duty for which you are well qualified?

DR. STANLEY KNEESHAW: Mr. Speaker, members of the House of Delegates and guests: This is the last official act of a Past President — and a very pleasant one it is indeed.

I would like to eulogize a bit on Don Cass. I know of no man in the California Medical Association who has given more of his time for the good of the medical profession and the people it serves than he has. I have known him for years; have served with him on committees; served on the Council with him; been with him as an A.M.A. delegate, and have watched with envy the way he gets things accomplished.

His broad knowledge of the problems that confront the medical profession is well known to us, and his advice and guidance in their solution has been excellent.

Don, the C.M.A. members will never be able to compensate you for the time you have given and the things you have done for them. The knowledge that you have served us well and that we admire you for it should give you a feeling of gratification. I hope that the fact that you will now be a Past President will not deter you from keeping active in the society.

The C.M.A. now awards you this small plaque as a token of its esteem for you and the honor of having had you as its President. May it give you as much pleasure as it has me as it looks down on you from the walls of your study.

Don, on behalf of the C.M.A. I thank you for your wonderful service to us.

PRESIDENT CASS: Thank you. Although I do want to make a speech, I can't do it.

SPEAKER ALESEN: Mr. Secretary, is there any other item of business on your table?

SECRETARY DANIELS: No, sir.

SPEAKER ALESEN: The editing of the Minutes is ordinarily done by a special committee. The House concurs in that practice, I take it, unless I hear some objection.

Are there any other items of business to come before us? If not, a motion to adjourn is in order.

. . . It was moved, seconded and carried that the meeting be adjourned at 11:30 p.m. . . .

In Memoriam

BECK, HORACE R. Died at Bryce Canyon, Utah, June 26, 1951, aged 67, of coronary artery disease. Graduate of the College of Physicians and Surgeons, Los Angeles, 1914. Licensed in California in 1914. Doctor Beck was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

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BENNETT, EDWARD C. Died at Ukiah, June 12, 1951, aged 62, of peritonitis. Graduate of the College of Physicians and Surgeons, Baltimore, Maryland, 1912. Licensed in California in 1917. Doctor Bennett was a member of the Mendocino-Lake County Medical Society, the California Medical Association, and the American Medical Association.

✤

BURNS, JAMES E. Died at Huntington Park, June 19, 1951, aged 46, of cerebral arteriosclerosis. Graduate of the University of California Medical School, Berkeley-San Francisco, 1933. Licensed in California in 1933. Doctor Burns was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

✤

ENGLISH, GLENN G. Died at San Fernando, June 11, 1951, aged 63. Graduate of Indiana University School of Medicine, Bloomington-Indianapolis, 1922. Licensed in California in 1924. Doctor English was a member of the Los Angeles County Medical Association, a retired member of the California Medical Association, and a Fellow of the American Medical Association.

✤

MARTIN, HARRY W. Died in Los Angeles, June 25, 1951, aged 61. Graduate of the University of Illinois College of Medicine, Chicago, 1912. Licensed in California in 1920. Doctor Martin was a member of the Los Angeles County Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

REED, ALFRED C. Died in Mill Valley, June 20, 1951, aged 66. Graduate of New York University College of Medicine, New York, 1910. Licensed in California in 1910. Doctor Reed was a member of the San Francisco Medical Association, the California Medical Association, and a Fellow of the American Medical Association.

✤

WOOD, DOROTHY A. Died in San Mateo, June 8, 1951, aged 57, of coronary artery disease. Graduate of Stanford University School of Medicine, Stanford University-San Francisco, 1919. Licensed in California in 1919. Doctor Wood was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Questions and Answers about C. P. S.

Question: **Recently I sent a C.P.S. patient to the hospital for an x-ray examination because of a suspected stomach ulcer. C.P.S. did not pay for either the hospitalization or the x-ray service. Why were these bills rejected?**

Answer: The question obviously refers to a case in which the hospitalization was primarily for laboratory and x-ray procedures which could have been rendered on an ambulatory basis. The member holding a surgical-hospital contract is eligible for diagnostic x-ray and laboratory procedures only when his condition necessitates his confinement as a bona fide registered bed patient. The C.P.S. hospital contract specifically excludes hospitalization that is only for the purpose of diagnostic work-up.

If the physician's opinion regarding the need for hospitalization, in a case such as the one above, is at variance with the position of C.P.S., he should so advise C.P.S. In no sense is C.P.S. trying to question the physician's professional judgment in the handling of a case, but rather is seeking to determine whether the conditions of the patient's contract are being correctly met. As it does not have first-hand knowledge of a case, C.P.S. sometimes has difficulty in judging whether a case is bona fide or not. Therefore, the physician's careful evaluation of each case is highly important.

Of significance with respect to this question is a resolution which was unanimously adopted by the C.P.S. administrative members at the annual convention in 1950. (Resolution No. 5, introduced by Dr. A. B. Carson of Alameda County.)

This resolution specifically called upon C.P.S. to ". . . make every effort, especially by the provisions of its contracts, to encourage the patient and his physician to use hospitals primarily for bed patients, and then only when needed to provide adequate medical care. . . ."

A number of vital considerations motivated the adoption of this resolution. For example: Acceptance of liability by C.P.S. for unwarranted cases tends to develop a situation in which utilization of C.P.S. funds exceeds normal expectations and creates a drain on the health plan's resources which is not justifiable under the rates established. Such a situation, if long continued, will lead to higher dues for members and a resultant lower public confidence in voluntary health care; and for C.P.S. physician members such a situation would materially handicap C.P.S. in its sincere efforts to improve fees for professional services.

The thinking behind this resolution also took into consideration that a large amount of unnecessary hospitalization could easily stimulate further governmental action for the building of hospitals, on the grounds of a scarcity of beds—which actually would be an artificial scarcity, resulting from unnecessary hospitalization. The resolution specifically pointed out that "...such governmentally sponsored hospitals would inevitably come under political control both as to admission and staff appointments."

Question: **Are any medical benefits available to C.P.S. members enrolled under the individual family plan?**

Answer: Yes. Individual family plan members have the option of subscribing for medical-services-while-hospitalized benefits by paying the additional cost over rates for their standard surgical-hospital coverage. All eligible family members must subscribe for this additional coverage in order for any one of them to obtain it.

Question: **What are the classifications of veterans who are eligible to receive out-patient medical care at government expense under the Home Town Care Program?**

Answer: There are three such classifications:

1. Veterans with service-connected disabilities are eligible for treatment for specific service-connected disabilities, or for conditions considered by the Veterans Administration to be adjunct to the service-connected disabilities. ("Adjunct" means a non-service-connected disability which is associated with, and held to be, aggravating the service-connected disability.)

2. Veterans in active vocational training under Public Law 16 are eligible for treatment of any conditions which would tend to interrupt their training.

3. Veterans of the Spanish-American War, Boxer Rebellion and Philippine Insurrection are eligible for treatment of any condition after they have applied to the Veterans Administration for treatment and an authorization has been issued for treatment of the specific condition. Both the application and the eligibility must be established separately for each new condition for which these veterans seek treatment.

Question: **Under the Veterans Program, why can't I receive blanket authorization for treating a veteran's disability, instead of trying to estimate the amount of services which will be needed?**

Answer: The Veterans Administration's funds for treating a veteran must be encumbered at the same time that authorization for treatment is issued. Thus, the amount of funds set aside by VA must depend upon the services for which the physician requests authorization.

NEWS and NOTES

NATIONAL • STATE • COUNTY

ALAMEDA

Dr. Edward S. Rogers, professor of public health and medical administrator on the Berkeley campus of the University of California, recently was appointed a member of the expert advisory panel on health statistics of the World Health Organization.

* * *

The National Foundation for Infantile Paralysis last month awarded $65,070 to the University of California Virus Laboratory to aid research under the direction of Dr. Wendell M. Stanley, professor of biochemistry. At the same time an award of $26,172 was made to the University of California School of Medicine in San Francisco to support work under the direction of Dr. LeRoy C. Abbott, professor of orthopedic surgery.

LOS ANGELES

Plans are being made for an outstanding scientific exhibit in connection with the **Clinical Session of the American Medical Association** to be held in Los Angeles, December 4 to 7. "There will be special exhibits on fractures, overweight, nutrition and health, and noise in industry," it was announced by Dr. George F. Lull of Chicago, secretary and general manager of the A.M.A.

"Main emphasis of the exhibit will be placed on the teaching value for the physician in general practice, but the interests of the specialists will not be overlooked," Dr. Lull said.

* * *

Dr. Erle Henriksen has been appointed clinical professor of gynecology at the University of Southern California School of Medicine.

SAN BERNARDINO

Dr. Virgil M. Pinkley, superintendent of San Bernardino County Hospital for the past 18 years, has announced he will retire from the post September 1. No successor has yet been named.

SAN FRANCISCO

Dr. Edwin Kerr, assistant in surgery in the University of California School of Medicine, San Francisco, has been awarded the $250 Helmut William Fesca Prize for 1951. The prize was established by various donors in memory of Dr. Helmut William Fesca, who was graduated from the School of Medicine in 1943.

* * *

The gold-headed cane, annually awarded to the senior medical student at the University of California School of Medicine who is deemed by fellow students and faculty members to have "the most outstanding qualities of a true physician" and to have shown "the greatest interest in the care of his patients," was presented this year to **Charles J. Carman.** John Lewis Linville and George W. Smith received honorable mention.

The cane award ceremony was inaugurated at the University of California School of Medicine in 1939. Each year the cane is passed from winner to winner.

SOLANO

Dr. Henry G. Mello, who since the first of the year has served as acting director of the Vallejo and Solano County Department of Public Health, has been appointed to permanent status. Dr. Mello took the place of Dr. L. S. McLean, who resigned January 1, 1951, to become chief of local health services, Montana State Department of Public Health.

GENERAL

The seventh annual meeting of the **Western Society of Electroencephalography** will be held in the Olympic Hotel, Seattle, Washington, September 7, 8, 9, 1951.

* * *

The 58th annual convention of the **Association of Military Surgeons of the United States** will be held at the Palmer House in Chicago, October 8 to 10. Advances in military medicine since World War II, and current problems arising out of the critical world situation and the Korean conflict, will be discussed.

* * *

The U. S. Food and Drug Administration is asking the help of physicians in **warning patients against a remedy** being mailed into this country from Mexico, which FDA describes as "worthless and extremely dangerous if employed as a substitute for insulin." If physicians know of diabetic patients who have the preparation, they may communicate the information to FDA, which will contact the patients immediately. It is said to be advertised as Cacalla Composita, Mexican Indian Root, and to be offered by "Mexican Indian Root Co., Mexico City," under the name of Dr. Miguel C. Martinez, general manager.

* * *

The 16th annual meeting of the **Mississippi Valley Medical Society** will be held at Peoria, Illinois, September 19 to 20. The entire program is planned to appeal to general practitioners. No registration fee will be charged. A program of the meeting may be obtained from Harold Swanberg, M.D., secretary, W.C.U. Building, Quincy, Ill.

POSTGRADUATE EDUCATION NOTICES

UNIVERSITY OF CALIFORNIA SCHOOL OF MEDICINE—Medical Extension, San Francisco

Gynecological and Obstetrical Conference:

August 29 through 31, 1951. Room 104, University Extension Building, 540 Powell Street, San Francisco. Fee: $50.00.

Ophthalmology:

September 10 through 15. Medical Center.

Guest Lecturer: Sir Stewart Duke Elder, M.D., Ch.B., F.R.C.S., Director of Research, Institute of Ophthalmology, University of London.

Evening Symposia in Medicine:

Sept. 10 through Nov. 26 (every Monday evening). Medical Center, Parnassus and 3rd avenues.

This is a series of evening exercises for general practitioners in the form of symposia on topics of particular interest to them.

Contact: Stacy R. Mettier, M.D., Medical Extension, University of California Medical Center, San Francisco 22, California.

STANFORD UNIVERSITY SCHOOL OF MEDICINE

Postgraduate Medical Courses for Practicing Physicians:

In cooperation with the San Francisco Department of Public Health and the San Francisco Hospital.

September 10, 11, 12, 13, 14, 1951.

Morning Courses: Monday, Tuesday, Wednesday, Thursday and Friday—8:30 a.m. to 12 noon.

COURSE 1—GENERAL MEDICINE (San Francisco Hospital—Limited to 20 physicians). Discussion of development, diagnosis, treatment and prognosis of various diseases will stem from cases presenting problems in internal medicine.

COURSE 2—GENERAL SURGERY (Stanford Hospital—Limited to 20 physicians). Selected general surgical topics will be reviewed in a series of ward rounds, clinics and lectures. Emphasis will be on the practical aspects of surgical treatment.

COURSE 3—UROLOGY FOR THE GENERAL PRACTITIONER (Stanford Hospital—Limited to 20 physicians). A practical course in the diagnosis and treatment of common urologic conditions. Detailed consideration will be given to office treatment, the use of modern antibiotics, infertility in the male, pyelographic interpretation, and to indications for and types of cystoscopic and operative procedures.

COURSE 4—PRACTICAL DERMATOLOGY (Stanford Hospital—Limited to 25 physicians). A practical course designed to emphasize diagnosis and treatment of the common dermatoses. Instruction will consist of numerous case presentations and discussions.

COURSE 5—DIAGNOSIS AND TREATMENT OF TUMORS (Stanford Hospital—Limited to 25 physicians). Cancer of the most frequent and accessible sites will be emphasized. Differential diagnosis, standard treatment and recent therapeutic developments will be stressed. The presentations will be didactic with critical discussion in which students will be invited to participate actively.

COURSE 6—GENERAL SURGERY (San Francisco Hospital—Limited to 30 physicians). General surgical ward rounds; groups of ten to single instructor.

COURSE 7—SURGICAL ANATOMY (Stanford Hospital—Limited to 20 physicians). Dissection of special regions and instruction and practice in the technique of various operations will be conducted in the dissecting room.

* * *

Afternoon Courses: Monday, Tuesday, Wednesday, Thursday and Friday—1:30 p.m. to 5:00 p.m.

COURSE 8—GENERAL MEDICINE (Stanford Hospital—Limited to 15 physicians). Clinical problems as they are affected by advances in fundamental knowledge will be discussed in selected fields. The subjects presented will be: pulmonary physiology and disease, hemorrhagic states, diabetes mellitus, syphilis, nutrition and the vitamins, electrolyte and water metabolism and the clinical use of cortisone and ACTH.

COURSE 9—SURGICAL ANATOMY (Stanford Hospital—Limited to 20 physicians). Dissection of special regions and instruction and practice in the technique of various operations will be conducted in the dissecting room.

COURSE 10—CARDIOLOGY (San Francisco Hospital—Limited to 25 physicians). Recent advances in clinical cardiology with sections devoted to electrocardiography and newer diagnostic methods and to present day medical and surgical treatment of cardiac disease.

COURSE 11—OBSTETRICS AND GYNECOLOGY (Stanford Hospital—Limited to 25 physicians). Informal discussions and demonstrations concerning amenorrhea, dysmenorrhea, disturbed uterine bleeding, birth trauma lesions, bleeding in pregnancy, therapeutic abortion, breech presentation, use of forceps, endometrial cancer and cytology in relation to incipient malignancy.

COURSE 12—PSYCHIATRY FOR GENERAL PRACTITIONERS (Stanford Hospital—Limited to 25 physicians). A presentation of the principles of psychiatry in general medical practice. Emphasis is on the practical procedures in diagnosis and treatment of commonly encountered disorders, especially in the psychosomatic area. Case presentation and panel discussion.

COURSE 13—ENDOCRINOLOGY (Stanford Hospital—Limited to 25 physicians). The course will summarize the physiology, the diagnosis and the treatment of disorders of the pituitary gland, the adrenals, the thyroid, and the male and female gonads. The management of diabetes, the metabolic effects of ACTH and cortisone, the parathyroids and bone disease, and the clinical uses of the sex steroids will be discussed. Lectures, case demonstrations and panel discussions.

COURSE 14—PEDIATRICS (Stanford Hospital—Limited to 25 physicians). Therapy in Pediatrics: Recent advances in therapy as it applies to infants and children will be discussed.

INFORMATION

Civilian Medical Care for Army Personnel

Generally, medical care and treatment, including hospitalization, are provided for Army personnel in the United States by dispensaries, infirmaries, and hospitals located at the many Army installations throughout the country. There are many locations, however, where Army or other United States federal medical treatment facilities are not available when medical service is required by Army personnel. In cases of this nature, the services of civilian physicians, clinics, and hospitals are necessary. With the expansion of the Army and the development of Army personnel to practically all points in the United States either on a duty, travel, or leave status, the continued cooperation of civilian physicians and agencies is of utmost importance in providing adequate medical service to the United States soldier in time of need.

Certain criteria and procedures have been established in connection with the furnishing of medical service to Army personnel by civilians in accord with the current laws and regulations. These criteria define the conditions under which individuals of the Army may be authorized civilian medical care at the expense of the Army. These procedures include methods for reporting and receiving payment for treatment or hospitalization of Army personnel by civilian medical agencies.

Civilian medical care (other than elective) at the expense of the Army is authorized for commissioned officers, contract surgeons when employed by the Army on a full-time basis, warrant officers, enlisted personnel, cadets of the United States Military Academy, general prisoners and prisoners of war when these personnel are on a duty status or when they are absent from their place of duty on leave or informal leave (pass) status. Applicants for enlistment in the Army and selectees also are authorized necessary civilian medical care at the expense of Army funds while they are being processed for enlistment or induction into the Army. Payment for civilian medical expenses incurred by Army personnel who are absent without leave is not authorized. Any obligations resulting from civilian medical care to Army personnel who are absent without leave are the responsibility of the Army individual concerned.

Normally, civilian medical care for Army personnel is authorized only when there are no other federal medical treatment facilities available. First aid or emergency treatment is authorized at any time, notwithstanding the proximity of Army or other federal medical treatment facilities. In this connection, emergency medical care may be defined as that required to save life or limb or prevent great suffering. Surgical operations should not be performed without prior approval of military authorities, unless indicated as an emergency procedure. Elective medical treatment in civilian medical treatment facilities or by civilian physicians will not be authorized, as Army funds cannot be used for payment of these services.

Due to limitation of funds available to the Army, medical care of dependents of military personnel from civilian sources, at Army expense, is not authorized. Dependents of military personnel may obtain available medical care at Department of Defense medical facilities only. Any obligations resulting from civilian medical care to dependents of military personnel are the responsibility of the dependents concerned or their sponsors.

As a general rule, the local military commander will furnish the civilian medical agency with prior written authority for ordinary medical care to Army personnel under his jurisdiction. In such cases, prior arrangements with the civilian medical agency will be made by the individual or by a proper military authority. In cases in which treatment is given in emergency without prior written authorization, the surgeon of the nearest military command should immediately be notified by the civilian medical agency, giving the individual's name, organization, nature of illness or injury and statement of the practicability of transfer of the patient to an Army or other governmental hospital. The civilian agency or physician then will be advised without delay by the appropriate military authorities as to procedures to be followed.

Bills for authorized medical care and treatment of Army personnel should be submitted to the commanding officer of the organization to which the patient belongs, or to the military authority who provided the authorization for the medical service. If the location of these individuals is not readily known, the bill should be sent to the appropriate military authority, in California to the Surgeon, Sixth Army, Presidio of San Francisco, California.

The bill should show the full name, rank, and service number of the patient, the place and inclusive dates of treatment, the diagnosis, and the charges, all itemized separately. The duty status of the patient at the time of illness or injury also should be shown, such as duty, leave, or pass. Payment will be expedited if the following certificate is typed on the bill and signed:

"I certify that the above charges are correct and just; that payment therefor has not been received; that the services were necessary in the care and treatment of the person named above; that the services were rendered as stated; and that the charges do not exceed those customarily charged in this vicinity."

....

Signature of Payee Title or Capacity

BOOK REVIEWS

THE DOCTOR—HIS CAREER, HIS BUSINESS, HIS HUMAN RELATIONS. By Stanley R. Truman, M.D., the William and Wilkins Company, Baltimore, 1951. 151 pages. $3.00.

Dr. Truman has done quite conscientiously what needs to be done every decade, namely: Providing a manual for the young doctor who is starting out on the rough paths of practice. Most of his conclusions would be concurred in by the vast majority of doctors and his recommendations for the guidance of young physicians in practical affairs are full of sound common sense and quite obviously the result of extensive and thoughtful experience. This experience, and his own particular interests, which are largely concerned with the improvement of general practice, do to a certain extent color his conclusions. This is perhaps shown more clearly in the section on group practice, for which, in spite of his effort to be fair, he makes it perfectly clear he has little use.

There is little in the book that would be valuable to the experienced physician unless the experienced physician finds himself in inexplicable difficulties, but for the use for which it was obviously intended, mainly the guidance of the beginner, it is completely adequate.

* * *

TEXTBOOK OF X-RAY DIAGNOSIS—Volume I—Head and Neck. Edited by S. Cochrane Shanks, M.D., F.R.C.P., F.F.R., Director X-Ray Diagnostic Department, University College Hospital, London; and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E., Director X-Ray Department, Westminster Hospital. Second Edition. 439 illustrations. W. B. Saunders Company, Philadelphia. 1951. 434 pages. $12.00.

This well known "English" textbook is appearing in newly arranged form. The present volume is divided into five sections, as follows: Central Nervous System by Cairns and Jupe, Teeth and Jaws by Worth, Eye by Reid, Accessory Nasal Sinuses by Graham-Hodgson, and Temporal Bone by Graham-Hodgson.

The section on Central Nervous System contains 41 more pages and 34 more illustrations than did the similar section in the first edition. There are four new pages on "pyography," a rather startling name for the introduction of opaque media into brain abscesses. There is a new chapter on cerebral angiography (spelled angeiography). As in the first edition, most of the illustrations are in positive form, and therefore of not as much benefit to the student and average physician as would be a negative form.

The section on Teeth and Jaws is almost identical with the first edition. It is a reasonably brief summary of the radiological diagnosis of conditions involving these structures.

The sections on Nasal Sinuses and Temporal Bone are rewritten, with some new illustrations and some new developments in technique.

The section on the Eye is very similar to the former section, except for the addition of eight pages on foreign body localization.

Volume II—The Chest. Edited by Shanks and Kerley. Second Edition, 605 illustrations, 702 pages, $15.00.

This edition is dedicated to Twining, the distinguished late co-author of this series of textbooks. As the title indicates, it deals with only two systems, leaving out the urogenital system formerly covered in this volume.

There is an increase of about one-third in the number of pages devoted to the cardiovascular and respiratory systems, the illustrations are almost doubled, and several are in color. The bibliography has been increased by some 80-odd names. Kerley has rewritten his section on the cardiovascular system and has revised the section on the respiratory system formerly written by Twining.

There are no major changes in chapters dealing with x-ray diagnosis of lesions of the cardiovascular system. There is fairly considerable rearragement of some of the headings in the respiratory system, and many developments such as the roentgen aspects of sarcoidosis, beryllosis, pulmonary adenomatosis, etc., are added.

The type throughout is large and easy to read. The illustrations are very clear (although many are in positive form). The two volumes are well indexed, and can be recommended to physicians, especially radiologists and those dealing extensively with disorders of the particular organ systems referred to.

* * *

ATLAS OF HUMAN ANATOMY—Volume I and II. By M. W. Woerfeman, M.D., F.R.N.A.Sc., Professor of Anatomy and Embryology and Director of the Department of Anatomy in the University of Amsterdam. The Blakiston Company, Philadelphia, 1950. $10.00 per volume; $18.00 per set.

This is a beautiful two-volume set of uniform, authentic, well-labeled anatomical illustrations all done in excellent tonal variations to clearly depict the points of interest. There is no written material whatsoever, and it is meant as an illustrative sourcebook of anatomical features of the bones, arteries, muscles, blood vessels, nerves, viscera, and central nervous system. In this regard it is an excellent reference book for surgeon and internist alike, and it would be an invaluable companion for dissecting-room work, if one contemplated using it at the student level. The two volumes together cost only $18.00, and it is certainly the most wonderful collection of anatomical drawings now obtainable at that price.

The reviewer would heartily recommend this book for students of anatomy, physicians who desire an accurate ready reference book without being burdened by reading anatomical verbiage to secure the desired information, surgeons, particularly if they would like a ready operating-room volume, and the general practitioner who often is seeking rapidly available anatomical information.

* * *

CHILD PSYCHIATRY IN THE COMMUNITY—A Primer for Teachers, Nurses, and Others Who Care for Children. By Harold A. Greenberg, M.D., Senior Psychiatrist, Institute for Juvenile Research, Chicago, Assistant Professor of Criminology, College of Medicine, University of Illinois; in collaboration with Julian H. Pathman, Ph.D., Chief Psychologist, Downey Veterans Administration Hospital; Helen A. Sutton, R.N., B.A., B.S., and Marjorie M. Browne, B.A., M.A. G. P. Putnam's Sons, New York, 1950. 296 pages. $3.50.

"Child Psychiatry in the Community," by Harold A. Greenberg, M.D., and his collaborators, who are all specialists within their respective disciplines, provides information regarding the clinic team. The evidence presented in this book shows that such integration can be developed in communities and that such teamwork is being utilized at local levels. It may serve as a most valuable guide for workers in this specialized and most important field.

The book is divided into three sections. The first section is about the child—psychogenesis of behavior problems, symptoms, diagnosis, and treatment. The second section is devoted to the clinic team, namely, the psychiatrist, psychologist, and social worker. It is well done and defines each

discipline's function and that such teamwork is the basic working unit of child guidance. The third section is devoted to the integration of the child guidance clinic and the community.

Throughout the entire book, examples are well documented. The appendix contains data on services of the psychiatric department of the Cook County Juvenile Court (Chicago). There is also a three-page glossary and a list of suggested readings.

This book affords a fund of information and is worthwhile reading—not only for the professional, but also for the layman interested in such a service for his community.

* * *

WHEELER AND JACK'S HANDBOOK OF MEDICINE. Revised by Robert Coope, M.D., B.Sc., F.R.C.P., Physician, Liverpool Royal Infirmary; Consulting Physician, King Edward VII Sanatorium, Midhurst; Lecturer in Clinical Medicine, Applied Physiology and Clinical Chemistry, University of Liverpool. Eleventh Edition. The Williams and Wilkins Company, Baltimore. 1950. 648 pages. $5.00.

This handbook is intended primarily for the student clerk on the wards. As the author writes: "When he has a patient suffering from peptic ulcer, or some blood disease, or bronchitis, or some other diseased condition, he can read something about it . . . (as) a preliminary sketching-in of a background to his experience. Later he will need to read much more, either in larger textbooks or in monographs." This summarizes fairly well the use and value of this elementary book.

It is a fairly small text which may be used to help the student get ready for an examination. Because of the differences between English and American medical practice, it has distinctly less value for the American student than for his British cousin. These differences are perhaps nowhere more obvious than in the therapy of infectious diseases: The sulfonamides are still the preferred treatment. The combination of sulfonamide and scarlet fever antitoxin is recommended for scarlet fever (pp. 27-28), while penicillin is not mentioned. Sulfathiazole is the method of choice for erysipelas (p. 30). The newer antibiotics, such as aureomycin and chloramphenicol, are not mentioned at all.

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A TEXTBOOK OF THE PRACTICE OF MEDICINE. By Various Authors. Edited by Frederick W. Price, F.R.S.Ed., M.D., C.M.Ed., F.R.C.P. Lond., Hon. M.D.Belf., Consulting Physician to the Royal Northern Hospital and to the National Hospital for Diseases of the Heart, London. Eighth Edition. Oxford University Press, 1950. 2075 pages. $9.00.

This new edition of Price's "Textbook of the Practice of Medicine" prompts a brief discussion of the differences between British and American textbooks of medicine. It is a book which has been through eight editions and 13 additional impressions in the course of 18 years. It is published by the Oxford University Press. It has a distinguished list of contributors. Yet its value to the American student and practitioner is considerably less than that of any one of several standard North American texts.

One reason is the factor of local color: There is a difference in the incidence and importance of various diseases in the British Isles (and the Commonwealth countries) and the United States. Another reason is the difference found in the patients involved and the way they are treated in the two countries. Then there is the nomenclature used, especially in therapy. The variances are often formidable enough to suggest a dictionary for proper translation between British and American terms. And of major importance is the reluctance of many British authors to detail newer methods of therapy (especially when those methods are developed in foreign countries).

Price's Textbook, a good, conventional British textbook of medicine, last revised in 1950, typifies all of these differences. To illustrate: New articles have been written on the antibiotics and sulfonamides. Penicillin is regarded as a drug which must be given intramuscularly at intervals of four hours or less. The suspension of penicillin in oil and beeswax is mentioned briefly. Procaine penicillin in aqueous suspension is apparently unknown. Two and a half lines mention that streptomycin "is still in the experimental stage" in the treatment of pulmonary tuberculosis (p. 1271), whereas nascent iodine is given five lines. Aureomycin and chloramphenicol are not mentioned. On the other hand, sulfonamides are still in high favor and are discussed as the treatment of choice in many disease conditions for which they are now considered obsolete in the United States literature.

Part of the therapeutic maladjustment results from the fact that the publication date in the U.S.A. was February 1951 while the editor (judging from the date on the preface) had finished with his chores for this edition by October 1949—a deplorable lapse of a year and a half.

As much as we regret it, we can recommend this volume only for the reference shelf of the library, to be used as a book to give the reader an additional slant on a subject he is investigating.

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HANDBOOK OF DIAGNOSIS AND TREATMENT OF VENEREAL DISEASES. By A. E. W. McLachlan, M.B., Ch.B. (Edin.), D.P.H., F.R.S. (Edin.), Consultant in Venereal Diseases, Bristol Clinical Area; Lecturer in Venereal Diseases, University of Bristol; Honorary Consultant in Venereal Diseases, Bristol General Hospital. With 160 illustrations, 20 in color. Fourth Edition. The Williams and Wilkins Company, Baltimore, 1951. 368 pages. $4.50.

This handbook is compiled from the author's lectures and clinics at the University of Bristol. The first edition appeared in 1944 and there have been three revisions largely because of changes in the therapy of venereal disease that have resulted from the introduction of penicillin and the other antibiotics.

About half the book is devoted to syphilis and there is too much emphasis on the trivial phases of the disease, so frequent in textbooks of dermatology. For example, the primary and secondary stages are given twelve times as much space as cardiovascular syphilis and over four times as much as neurosyphilis.

In the treatment of syphilis, penicillin is recommended with caution and it is not advocated as the sole therapeutic agent, but only in conjunction with quite large amounts of arsenic and bismuth. Such treatment has been considered obsolete in this country for a number of years.

Gonorrhea is discussed at considerable length. Penicillin is the treatment of choice, but the recommended doses are larger than those usually used. After treatment, observation is said to be necessary for a period of six months with many clinical and bacteriological examinations and a final "test of cure" involving instrumentation and the application of chemical "provocatives" prior to the last smear or culture. In this country, the failure rate after penicillin therapy is so low that follow-up examinations usually are not made in the absence of clinical symptoms. Several other minor venereal diseases are discussed briefly.

This handbook emphasizes the immediate care of the infectious stages of the venereal diseases. In an apparent desire to be conservative, the author continues to advise the use of outmoded and hazardous forms of therapy that should have been discarded long ago. It is probably of some value from the standpoint of venereal disease control but it is too superficial to be of much use in solving any of the more complex problems that are presented by so many patients with infections in this field.

BRONCHOESOPHAGOLOGY. By Chevalier Jackson, M.D., Sc.D., LL.D., F.A.C.S., Honorary Professor of Bronchoesophagology and Laryngeal Surgery, Temple University; and Chevalier L. Jackson, M.D., M.Sc., F.A.C.S., Professor of Bronchoesophagology and Laryngeal Surgery, Temple University. Illustrated. 366 pages. W. B. Saunders Company, Philadelphia, 1950. $12.50.

This book is represented in a more up-to-date form and with more added material than the former edition by the authors. As usual this represents a classic in medical textbooks. The excellent full-color drawings by one of the authors are reproduced from the older works.

The chapter on anatomy has introduced into it the Jackson-Huber terminology for the pulmonary segments and their bronchi. By the aid of excellent drawings their concept of bronchial anatomy is clearly demonstrated. The main portion of the book is divided into sections on bronchology and esophagology. The subjects of anatomy and physiology are well covered. The techniques of bronchoscopy and esophagoscopy as practiced at the authors' clinic for diagnostic and therapeutic purposes are well delineated. Numerous illustrations, drawings and x-ray reproductions add to the clearness.

The paper, printing and general format are excellent. The only adverse criticism to be offered is the little space devoted to bronchoscopy with optical lens system which has so aided bronchoscopists in the last few years in the practice of their art.

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THE PHYSIOLOGY AND PATHOLOGY OF HEMOSTASIS. By Armand J. Quick, Ph.D., M.D., Professor of Biochemistry, Marquette University School of Medicine. 18 illustrations. Lea & Febiger, Philadelphia. 1951. 188 pages. $4.00.

This interesting volume is designed to give the reader an historical summary and limited background of present-day views and researches upon the subject of the coagulation of the blood. The theories of hemostasis are given in detail in Chapter One. An extensive bibliography accompanies this phase of the volume.

Chapter Two is entitled, "A New Theory of the Coagulation of the Blood and a Unified Concept of Hemostasis," and the author offers his own hypothesis, in which it is held that the coagulation mechanism, particularly the group of reactions leading to the formation of thrombin, plays a vital and coordinated role in hemostasis. Thrombin, in addition to clotting fibrinogen, labilizes platelets, thereby initiating a chain reaction, since the agent liberated by the platelets activates thromboplastinogen. The author believes that the disintegrating platelets supply in addition a vasoconstrictor principle. Through the latter, the coagulation reaction is linked with the vascular factors in hemostasis. In addition to the vasoconstrictor effect of disintegrated platelets, a primary vascular contraction, probably reflex in nature, also contributes to the process of stanching blood. The fibrin clot, it is stated, does not function primarily as a static mechanical plug, but rather as a reservoir of entrapped platelets and an adsorbent of thrombin whereby it localizes thrombi and maintains sustained local hemostasis by a continuous liberation of the vasoconstrictor principle.

The author discusses in detail the classification of hemorrhagic diseases and their diagnosis under five main headings: (a) bleeding diseases due to vascular defects, (b) bleeding diseases due to factors in the blood (hypothromboplastinemias and hypoprothrombinemias), (c) hypofibrinogenemia, (d) platelets deficient in vasoconstrictor principle (hypothetical), and (e) heparinemia. A special chapter is devoted to the treatment of the hemorrhagic diseases and the surgical handling of problems concerning altered coagulability of the blood. The subject of venous thrombosis and a consideration of its mechanism and treatment is a welcomed addition. To this is appended a discussion of the antithrombins and anticoagulants.

The section dealing with laboratory methods is exhaustive and outlines instructions for 21 laboratory tests used and perfected by the author, i.e., coagulation time, bleeding time, platelet count, clot retraction, tourniquet test, thromboplastin preparation and assay, quantitative determination of prothrombin, prothrombin consumption test, assay of thromboplastinogen, assay of thrombin; estimation of fibrinogen, assay of heparin, prothrombin adsorbents, assay of vitamin K and determination of potency of prothrombinopenia-inducing agents, etc.

To those who are interested in the subject of the coagulation of the blood, the volume is recommended as a resume of the author's published works on the subject.

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ALLERGY: FACTS AND FANCIES. By Samuel M. Feinberg, M.D., Associate Professor of Medicine, Chief of Section of Allergy and Director of Allergy Research Laboratory, Northwestern University Medical School. Harper and Brothers, New York, 1951. 173 pages. $2.50.

The publication of another text on allergy for the lay person must be justified on the basis that it is an improvement on the many texts already published. This point is stressed by the author in the preface. That Dr. Feinberg has more than justified the writing of "Allergy: Facts and Fancies" must be evident to anyone familiar with other lay texts on allergy. The reviewer is convinced that the author has made another ten-strike. Anyone familiar with his textbook on "Allergy in Practice" must be impressed with the skill with which he has been able to reduce the complex facts underlying allergic manifestations to simple language.

In this small book he has presented in lucid style the symptoms, causes and methods of treating the common allergic diseases. The author is to be commended for his conservative evaluation of the results achieved by present methods of treatment. This will aid the layman in a better understanding as to what may or may not be expected from allergic treatment. As the author points out, the results are at times so encouraging that a knowledge of this fact will discourage the patient from self-medication.

The newer drugs and hormones, such as the antihistaminic agents and ACTH and cortisone, are evaluated in a simple manner intelligible to the average lay person.

The book may serve also as a simple text to give the general practitioner and the nurse the fundamental facts of our present knowledge of allergic diseases and treatment.

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INDUSTRIAL HEALTH AND MEDICAL PROGRAMS—Statements, Tables and Charts. Selected and compiled by Margaret C. Klem, Margaret F. McKiever, and Walter J. Lear, M.D. Public Health Service Publication No. 15. Federal Security Agency, Public Health Service, Division of Industrial Hygiene, Washington, D. C., September 1950. 397 pages. $1.00—Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C.

The field of industrial injury and sickness care has efflorescd in recent years into an enormous industrial health program. This expansion is partly due to a desire on the part of physicians and employers to provide more comprehensive care to workers and partly to meet a demand for increased wages in concealed form. In this remarkable reference book is a collection of data and opinions on industrial health and medical care programs selected from 260 books and publications.

The initial three sections provide background information about industry, the working population, the health of the worker, and the historical development of industrial health schemes. The next three sections describe various plant health and medical services, their type, extent, costs and

apparent savings. The two final sections concern other health and medical programs for industrial workers, including partial information on prepayment medical care plans, governmental industrial hygiene services, disability programs and various vocational rehabilitation programs.

The detailed information on national income, the labor force, and the type and size in industrial establishments is of considerable interest. The data are supposedly correct up to the time of publication, September 1950. The summary of the historical development of industrial health and medical care is something which should be of interest to all physicians currently in practice. Such dates as the initiation of the plan to keep hospital beds occupied (Blue Cross), to keep private medicine out of political control (Blue Shield), etc., are duly listed.

The information on types and extent of plant health and medical services is of interest, but like so much documentary information of this type does not and cannot tell the full story. The "planners'" program is often quite different from the actual one. The final section on health programs, disability programs and welfare agency groups clearly foreshadows further extension of government or union labor into medical care plans. Physicians, read and be forewarned. Young physicians, read and plan accordingly.

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THE KIDNEY—Structure and Function in Health and Disease. By Homer W. Smith, A.B., Sc.D., M.S., Professor of Physiology, New York University College of Medicine. Oxford University Press, New York, 1951. 1049 pages. $12.50.

For two decades Homer W. Smith has applied himself to the problem of renal physiology. From the depths of his own knowledge, and with breadth of scholarship which has carried him ably from the healthy lung-fish to ailing man, he has now compiled a monumental classic describing our present understanding of renal function and related topics.

As might be expected from the author of "The Physiology of the Kidney" (1937), this work devotes much of its space to normal physiology. There are detailed accounts of glomerular filtration, tubular reabsorption and excretion, the effects of antidiuretic and of adrenocortical hormones, excretion of sodium and other electrolytes, acid-base equilibria, renal circulation, effects upon the kidney of various hormones, vitamins and diets, renal function in the very young and in the aged, and comparative physiology. Material of this sort occupies about half the book; in it will be found much of interest not only to physiologists but also to clinicians and pharmacologists.

More than 300 pages are then concerned with the kidney in abnormal states; important general headings include proteinuria, disturbances of salt and water balance, disturbed renal function in non-renal diseases, congestive heart failure, essential hypertension, acute renal failure, glomerulonephritis, pyelonephritis, the nephrotic syndrome, and the actions of diuretics. In this section one is pleased to find not only extensive (and very recent) references to the literature, but also Smith's personal views on such controversial subjects as Trueta's shunt, "lower nephron nephrosis," and the role of the kidney in the pathogenesis of congestive failure and hypertension.

There is relatively little discussion of structure and no attempt to illustrate lesions, the author wisely having left this to others who are trained in pathology. The index seems rather brief, yet is adequate when used thoughtfully. There is an extensive bibliography, in which the works of Thomas Addis and his followers are prominent. The physical appearance is attractive. Oddly enough, one feels a sense of reassurance in noting a small number of minor typographical errors. It is almost superfluous to add that the book is recommended most highly.

HANDBOOK OF MEDICAL MANAGEMENT (2nd Edition). By Milton Chatton, A.B., M.D., Instructor in Medicine; Sheldon Margen, A.M., M.D., Clinical Instructor in Medicine; and Henry D. Brainerd, A.B., M.D., Assistant Clinical Professor of Medicine and Pediatrics, all of University of California School of Medicine. University Medical Publishers, Post Office Box 761, Palo Alto. 1951. 508 pages. $3.00.

This highly compressed and intelligently opinionated manual is written primarily from the viewpoint of medical management in hospital and clinic practice. However, it can be heartily recommended for the desk and bag of the practicing physician as well as for the pocket of the student and house officer.

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A FEW BUTTONS MISSING—The Case Book of a Psychiatrist. By James T. Fisher, M.D., and Lowell S. Hawley. J. B. Lippincott Company, Philadelphia, 1951. 282 pages. $3.50.

The cleverness and humor of the title of this book, "A Few Buttons Missing," so aptly describing many of a psychiatrist's patients, extend throughout the whole volume.

It is the story of the professional and personal life of a psychiatrist, 87 years young. Beautifully written, full of wit, humor, human interest and common sense, it should appeal to both laymen and physicians. The author's down-to-earth attitude toward the intricacies of psychiatry is pleasing.

Your reviewer believes you will be delighted with this book.

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PIONEER DOCTOR. By Lewis J. Moorman, M.D., University of Oklahoma Press, Norman, Oklahoma, 1951. 252 pages. $3.75.

This account of the life and experiences of a country doctor, who later became a specialist in a large city, is well written and will be of interest to physicians and laymen.

The first half of the book, dealing with the author's years in general practice, is especially interesting. The second half is less so; for, in dealing with his experiences as a phthisiologist, the author has included much that is too commonplace for physicians and rather uninteresting for laymen. But, all in all, it is quite worthwhile.

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EYE MANIFESTATIONS OF INTERNAL DISEASES (MEDICAL OPHTHALMOLOGY). By I. S. Tassman, M.D., Associate Professor of Ophthalmology, Graduate School of Medicine, University of Pennsylvania, Philadelphia; Attending Surgeon, Wills Eye Hospital, Philadelphia, Pa. Third Edition. 279 illustrations, including 25 in color. The C. V. Mosby Company, St. Louis, 1951. 672 pages. $12.00.

The second edition of this text of medical ophthalmology was reviewed in CALIFORNIA MEDICINE (p. 105, Feb. 1947). The third edition has added 60 pages; it contains a revision of the subject of glaucoma and additions on a variety of other subjects. It retains, however, most of the defects pointed out in the earlier review (one exception: it is rewarding to note that the discussions on treatment now acknowledge the existence of penicillin). It still fails to achieve its avowed and worthy purpose of integrating ophthalmology into internal medicine.

The book has its principal use for the student of ophthalmology. As far as the internist is concerned, it is a "reference in reverse," to which he can turn only rarely. An example of its limitations may be found on pages 320 and 321, the section on rheumatoid arthritis: There is a fairly adequate summary of the general and joint aspects of the disease, too elementary to be of use to the internist or the general practitioner, but perhaps informative enough for the purpose of the ophthalmologist. On the other hand, uveitis, which may occur in this disease, is barely mentioned, although discussion of it would be of distinct aid to the internist.